IN THE UNTED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA d/b/a PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v. **No.** 4:19-cv-46-BRW

ARKANSAS BOARD OF HEALTH — **DEFENDANT**

NOTICE OF REMOVAL

Defendant Arkansas Board of Health removes this action from the Circuit Court of Pulaski County, Arkansas, pursuant to 28 U.S.C. § 1441.

1. Plaintiffs operate licensed abortion facilities in Arkansas. After inspecting Plaintiffs' facilities in January and February 2018, the Board discovered that Plaintiffs were not complying Arkansas's Woman's Right-to-Know Act. Among other things, the Act prohibits Plaintiffs from "requir[ing] or obtain[ing] payment for a service provided in relation to abortion . . . until the expiration of the forty-eight-hour reflection period" that the Act requires. Ark. Code § 20-16-1703(d). The Board then issued an order finding Plaintiffs in violation of that prohibition.

2. Plaintiffs claim that section 20-16-1703(d) and the Board's order based on that section violate the U.S. and Arkansas Constitutions. Plaintiffs initially filed a petition for a writ of mandamus in which they argued that the Board's order did not comply with Arkansas administrative-procedure law. But on January 21, 2019, they made clear in their reply brief in support of their mandamus petition that the petition is a vehicle for pursuing their constitutional claims. They "claim that Ark. Code Ann. § 20-16-1703(d) violates the taking clauses of the U.S.

This case assigned to District Judge Wilson
and to Magistrate Judge Volpe

Constitution and the Arkansas Constitution; the equal protection clauses of the U.S. and Arkansas Constitutions, the privacy rights of the U.S. and Arkansas Constitutions; and the Contracts Clause of the U.S. Constitution." Reply to Response to Petition for Writ of Mandamus at 4 n.1, *Little Rock Family Planning Servs. v. Ark. Bd. of Health*, No. 60cv-18-8090 (Jan. 21, 2019, Pulaski Cty. Cir. Ct.).[1] Plaintiffs filed a mandamus petition, in other words, to ensure "that these constitutional issues are preserved for review in this Court"—*i.e.*, the Pulaski County Circuit Court—"and on appeal to the Arkansas Supreme Court, if necessary." *Id.* at 4.

3. At a January 22 hearing on Plaintiffs' petition for a writ of mandamus and other matters, the Pulaski County Circuit Court denied that petition but proceeded to the merits of Plaintiffs' claims under the U.S. and Arkansas Constitutions. That court found on the record a substantial probability that section 20-16-1703(d) violated either or both Constitutions.

4. This action is removable pursuant to 28 U.S.C. § 1441(a) because Plaintiffs' claims arise under the Constitution of the United States. *See* 28 U.S.C. § 1331 (providing federal courts with original jurisdiction over civil actions arising under federal law).

5. This Court has supplemental jurisdiction over Plaintiffs' state-law constitutional claims pursuant to 28 U.S.C. § 1367(a) and § 1441(c) because they are so related to the federal claim as to "form part of the same case or controversy under Article III of the United States Constitution." 28 U.S.C. § 1367(a).

6. This Notice of Removal is timely filed within 30 days after the Board's receipt "of an amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable." 28 U.S.C. § 1446(b)(3).

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[1] Plaintiffs' reply brief is included in the state-court record being filed simultaneously with this Notice of Removal.

7. True and correct copies of all process, pleadings, and orders served upon the Board are filed together with this Notice of Removal as required by 28 U.S.C. § 1446(a).

8. Pursuant to 28 U.S.C. § 1446(d), the Arkansas Board of Health will promptly serve upon Plaintiffs' counsel and file with the Circuit Court of Pulaski County, Arkansas, a true and correct copy of this Notice of Removal.

For these reasons, the Arkansas Board of Health removes this action from the Circuit Court of Pulaski County, Arkansas, to this Court pursuant to 28 U.S.C. § 1441.

Respectfully Submitted,

LESLIE RUTLEDGE
Arkansas Attorney General

By: 

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Attorneys for Defendant

CERTIFICATE OF SERVICE

I, Dylan L. Jacobs, hereby certify that on January 22, 2019, I served a copy of the foregoing by electronic mail and U.S. Mail, postage prepaid, upon the following:

Bettina E. Brownstein

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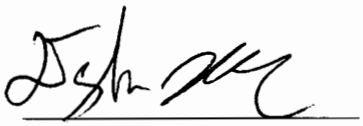
bettinabrownstein@gmail.com



Dylan L. Jacobs

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS

_____ DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA DBA PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v.

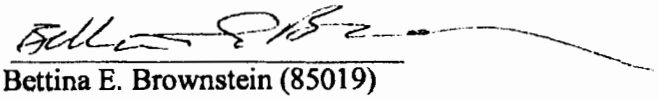
ARKANSAS BOARD OF HEALTH — **DEFENDANT**

APPEAL FROM ADMINISTRATIVE DECISION

Plaintiffs Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains appeal from an order of the Arkansas Board of Health ("ÄBOH") issued November 8, 2018 which is adverse to Plaintiffs. Plaintiffs' research indicates that the order is insufficient under the law to permit judicial review of the order and have thus filed a motion with the ABOH requesting that it revise its order. However, to prevent any waiver or default of their ability to appeal, Plaintiffs file this timely notice of appeal. In the event Defendant revises its order, as requested by Plaintiffs, Plaintiffs is likely to file an amended notice of appeal.

Designation and transmittal of the record is governed by Ark. Code. Ann. §25-15-212, which requires Defendant to transmit at its cost the entire record of the proceedings below for this appeal.

Respectfully submitted:



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On Behalf of Arkansas Civil Liberties Foundation,
Inc. for Plaintiff Little Rock Family Planning Services

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November 26, 2018

Via E-mail to Monty Baugh at monty.baugh@arkansasag.gov

Re: Appeal from Arkansas Board of Health Decision v. Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains, Case No. 60cv-18-8090, Pulaski Circuit Court.

Mr. Monty Baugh, Assistant Attorney General
Arkansas Attorney General
323 Center St., Suite 200
Little Rock, Arkansas 72201

Dear Monty:

This letter is to inform you that Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains have appealed a decision of the Arkansas Board of Health to the Pulaski Circuit Court. The case no. is referenced above. In this appeal, Plaintiffs challenge the constitutionality of Ark. Code Ann. § 20-16-1703(d).

Cordially,

Bettina E. Brownstein
Attorney for Plaintiffs

Report Selection Criteria

Case ID: 60CV-18-8090
Citation No:
Docket Start Date:
Docket Ending Date:

Case Description

Case ID: 60CV-18-8090 - LR FAMILY PLANNING SERV ET AL V AR BOARD OF HEALTH *-NON-TRIAL*
Filing Date: Monday , November 26th, 2018
Court: 60 - PULASKI
Location: CI - CIRCUIT
Type: AP - ADMINISTRATIVE APPEAL
Status: OPEN - CASE OPEN
Images:

Case Event Schedule

No case events were found.

Case Parties

Seq #	Assoc	End Date	Type	ID	Name
1			JUDGE	7965389	**HON. TIM FOX - 6TH DIVISION PULASKI CIRCUIT COURT**
				Aliases:	FOX
2			PLAINTIFF	16378044	**LITTLE ROCK FAMILY PLANNING SERVICES**
				Aliases:	*none*
6			DEFENDANT	16378046	**ARKANSAS BOARD OF HEALTH**

				Aliases:	*none*
4			DEFENDANT/RESPONDENT ATTORNEY	1005736	**KEHLER, LAURA KATHERINE**
				Aliases:	*none*
5			PLAINTIFF/PETITIONER ATTORNEY	1003620	**BROWNSTEIN, BETTINA ELLEN**
				Aliases:	BROWNSTEIN, BETTINA E.
3			PLAINTIFF	16378045	**PLANNED PARENTHOOD GREAT PLAINS**
				Aliases:	*none*

Violations

Sentence

No Sentence Info Found.

Milestone Tracks

No Milestone Tracks found.

Docket Entries

Filing Date	Description	Name	Monetary
	AOC COVERSHEET CIVIL		

11/26/2018 02:48 PM		BROWNSTEIN, BETTINA ELLEN	
Entry:	*none.*		
Images	No Images		
11/26/2018 02:48 PM	COMPLAINT/PETITION FILED $	BROWNSTEIN, BETTINA ELLEN	
Entry:	Appeal from Administrative Decision		
Images	WEB		
11/26/2018 02:48 PM	MOF ORIGINAL	BROWNSTEIN, BETTINA ELLEN	
Entry:	*none.*		
Images	No Images		
11/26/2018 02:57 PM	PAYMENT RECEIVED		
Entry:	A Payment of $165.00 was made on receipt 60CI343597.		
Images	No Images		

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA DBA PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS/PETITIONERS**

v. — **Case No. 60cv-18-8090**

ARKANSAS BOARD OF HEALTH — **DEFENDANT/RESPONDENT**

CATHERINE TAPP, PERRY AMERINE, MARSHA BOSS, GREG BLEDSOE, GLEN "EDDIE" BRYANT, VANESSA FALWELL, ALAN FORTENBERRY, PHILLIP GILMORE, ANTHONY N. HUI, DAVID KIESSLING, CARL MIKE RIDDELL, ROBBIE THOMAS KNIGHT, SUSAN WEINSTEIN, TERRY YAMAUCHI, DR. JAMES ZINI, NATHANIEL SMITH, MEMBERS OF THE ARKANSAS BOARD OF HEALTH, In Their Official Capacities. — **RESPONDENTS**

PETITION FOR WRIT OF MANDATE

Pursuant to Ark. Code Ann §§16-115-101, Plaintiffs/Petitioners Little Rock Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains ("PPAEO") (collectively "Petitioners") bring this Petition for a Writ of Mandate and state:

Jurisdiction and Relief Sought

This Court has jurisdiction of this matter pursuant to Ark. Code Ann. § 16-115-101. Petitioners seek a writ of mandamus to compel Respondents to perform a purely ministerial act, which is required by Ark. Code Ann. §25-15-210 of the Arkansas Administrative Procedures Act and decisions of the Arkansas Supreme Court. Specifically, Petitioners seek a writ of mandamus to compel Respondents to issue an order *In the Matter of Arkansas Dept. of Health v. Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains* that complies with § 25-15-210 and Arkansas Supreme Court precedent. The requested writ is necessary for Petitioners to obtain appellate review of a decision of the Arkansas Board of Health ("Board") which is adverse to Petitioners. Without the writ of mandamus compelling an appropriate order from the Board, under *Hanks v. Sneed,* 235 S.W. 3d 883, 890 (Ark., 2006), Petitioners will be unable to obtain the judicial review they seek and to which they are entitled by law. *See* Ark. Code. Ann. § 25-15-212. Petitioners have no other remedy or means of obtaining the relief sought other than through this petition.

Background Facts

LRFPS and PPAEO's two health centers in Arkansas received Statements of Deficiencies from the Arkansas Department of Health ("ADH") in March of 2018, citing them for violations of Ark. Code Ann. § 20-16-1703(d), which bans a patient from paying for mandated abortion health care services mandated by state law until the expiration of 48 hours after the services are provided. Petitioners disputed the legitimacy of the citations, initiated administrative appeals seeking their dismissal, and requested a hearing before the Board in accordance with Ark. Code. Ann. § 20-15-208. Petitioners and ADH agreed to a joint adjudication by the Board on the administrative appeals and also agreed that the adjudication be conducted on written submissions

without the necessity of live testimony or argument. Petitioners and ADH further agreed to a briefing schedule that required all written materials be submitted to the Board by October 11, 2018, which allowed ample time for board members to review them before the Board's October 25, 2018 hearing and adjudication.

Petitioners submitted an opening brief with supporting affidavits on September 6, 2018. ADH submitted a response September 27, 2018; and Petitioners submitted a reply with additional supporting affidavits October 11, 2018. Copies of these documents are attached as Exhibits 1-3 to this petition. In their opening brief, Petitioners raised eight separate and specific arguments that challenged the legitimacy of ADH's actions in issuing the Statements of Deficiencies and in addition, moved for a dismissal of the citations. These specific challenges were:

(1) The statute upon which the citations are based, Ark. Code Ann. § 20-16-1703(d), as now interpreted by ADH, ("the Payment Ban"), violates the takings clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 22 of the Arkansas Constitution;

(2) The Payment Ban violates the equal protection clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 18 of the Arkansas Constitution;

(3) The Payment Ban violates the privacy rights of Respondents' patients, as guaranteed by the U.S. and Arkansas Constitutions;

(4) The Payment Ban violates the Contracts Clause of the U.S. Constitution, Art. 1, § 10.

(5) The Payment Ban constitutes tortious interference with contract in violation of Arkansas common law;

(6) ADH exceeded its authority in issuing the deficiency citations absent a regulation or rule prohibiting this conduct, and, under Ark. Code Ann. § 20-7-109(c), its interpretation of the

law as prohibiting payment for services provided at a patient's first visit until the lapse of 48 hours interferes with the practice of medicine;

(7) Issuance of the deficiency citations was arbitrary and capricious, as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit before the lapse of 48 hours; and

(8) Issuance of the deficiency citations was arbitrary and capricious as PPAEO's practice of gathering credit card information at the first visit and then charging patients for services only after a delay of at least 48 hours complies with Ark. Code Ann. § 20-16-1703(d).

ADH, in its response to Petitioners' initial brief, separately addressed Petitioners' non-constitutional bases for the administrative appeals (with the exception of number 6, which it ignored.) Petitioners, in their reply, addressed ADH's responses, again separately setting out the facts and arguments for each issue.

On October 25, 2018, the Board met to deliberate and decide whether to uphold or dismiss the citations. On October 31, 2108, Petitioners, through counsel, communicated by email with Laura Shue, General Counsel for ADH and the Board, advising her that the law required a ruling on each individual issue raised by Petitioners, including the constitutional ones. A copy of this email is attached as Exh. 4. On November 8, 2018, ABH issued its order, entitled Stipulated Facts, Conclusions of Law and Order, a copy of which is attached as Exh. 5. On November 14, 2018, Petitioners submitted a motion to the Board, which noted that the November 8, 2018 order did not comply with Arkansas law because it failed to set out findings of fact and conclusions of law separately stated, as required by § 25-15-210, and that decisions of the Arkansas Supreme Court required a ruling from the Board on each issue raised by Petitioners, even the constitutional ones, to preserve their arguments for appeal to the circuit

court. A copy of this motion is attached as Exh. 6. On December 3, 2018, the Board responded to the motion by declining to revise the original order, stating that the original order was sufficient. A copy of this response is attached as Exh. 7.

Argument

Arkansas law authorizes a circuit court to issue a writ of mandamus to an executive agency to compel an executive officer to perform an act, to enforce an established right. or to enforce the performance of a duty. *See* Ark. Code Ann. §§ 16-115-101(a); *City of North Little Rock v. Pfiefer*, 2017 Ark. 113, *4 (Ark. 2017) (citing *Smith v. Fox*, 358 Ark. 388, 193 S.W. 3d 238 (2004)). "When requesting a writ, a petitioner must show a clear and certain right to the relief sought and the absence of any other adequate remedy." *Manila Sch. Dist. No. 15 v. Wagner.* 357 Ark. 20, 159 S.W. 3d 285 (2004). Mandamus is an appropriate remedy when a public officer is called upon to perform a plain and specific duty which is required by law and which requires no exercise of discretion or official judgment. *See Weaver v. Collins,* 2010 Ark. App. 707, 379 S.W.3d 582 (Ark. App., 2010).

Pfeifer is instructive here. In *Pfeifer*, which involved a property owner seeking to have an improvement district established by ordinance, the Arkansas Supreme Court upheld a lower court's grant of a writ of mandamus because the North Little Rock city council had failed to perform its duty as mandated by statute. 2017 Ark. 113, * 4. The statute in question in *Pfeifer* (Ark. Code Ann. § 14-88-207(a)(1)(2)(A)) required a city council to make a finding as to whether a "petition [to create an improvement district] is signed by a majority in assessed value of the property owners" and further required that the finding "shall be expressed in an ordinance." *Id.* The Court found that the petitioner had shown an established right to a writ

because use of the word "shall" in the statute meant that the legislature intended mandatory compliance with it unless such interpretation would lead to an absurd result." *Id.*

Applying the principles discussed above, Petitioners are entitled to the writ they seek. Petitioners are not asking this Court to specify the substance of the findings of fact or conclusions of law Respondents must include, only that findings and conclusions on each of the issues raised by Petitioners administrative appeal and conclusions be made and included in a revised and amended order, as required by Ark. Code Ann. § 25-15-210, which states, "A final decision **shall** include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings." Thus, Petitioners are not seeking a mandate as to any discretionary action on the part of Respondents but only the ministerial one of making the requisite findings and conclusions.

The Board's order fails to obey the "shall" of § 25-15-210. It fails to address the eight separate grounds for appeal contained in Petitioners' opening brief or even the non-constitutional grounds, which were separately addressed in ADH's response (Exh. 2) and again in Petitioners' reply (Exh. 3). As to Petitioners' constitutional claims, the order recites only that "to the extent that respondent raised constitutional claims against enforcement of the state statute, the Department states that the constitutional claims raised are "presumed to be constitutional and enforced by law" and further states that it has "reviewed and considered the constitutional claims but that the Board lacks authority "to declare unconstitutional a statute that the Department is required to enforce." Exh. 5. The one non-constitutional claim that Respondent separately addresses is the tortious interference with contract claim, which the Board argues is barred by sovereign immunity. Exh. 5. Instead of making the required findings and conclusions, the order

recite five "Stipulated Facts" (which are not disputed but which, in fact, were not stipulated to by Petitioners) in a separate section and four "Conclusions of Law" in a separate section. The "Stipulated Facts" section ignores the many facts asserted in Petitioners' submissions to the Board -- none of which were disputed by ADH. However, none of these undisputed facts is included in the order. Moreover, the "Conclusions of Law" do not even mention the separate challenges Petitioners made to the validity of the deficiency citations, much less decide them -- including the challenges that it was arbitrary and capricious for ADH to consider Petitioners' conduct in violation of the payment prohibition and that the payment prohibition impermissibly interferes with the practice of medicine. Exh. 5. The order's Stipulated Facts and Conclusions of Law are mere labels and are not in any way a meaningful attempt to comply with the law.

A mandate is necessary to compel the Board to comply with the law and issue a revised and amended order that includes findings of fact and conclusions of law for each issue raised by Petitioner on their administrative appeal. Without such an order, it is highly unlikely that Petitioners will be unable to obtain judicial review of the separate issues Petitioners raised before the Board and intend to raise on their appeal of the Board's decision to this Court. *See Hanks v. Sneed,* 235 S.W. 3d at 890 (citing *Arkansas Contractors Licensing Bd. v. Pegasus Renovation Co.*, 347 Ark, 320, 64 S.W. 3d 241 (2001)). In *Hanks,* James Hanks brought suit in circuit court challenging, *inter alia,* an order from the Board which upheld ADH's actions in denying him a certification to qualify as an Emergency Medical Technician. *Id.* at 866. The circuit court affirmed the Board's order. Hanks appealed the circuit court's ruling to the Arkansas Supreme Court. The Court reviewed the decision of the agency rather than that of the court. *Hanks*, 235 S.W. 3d at 890. The Court found that the Board had not decided the individual issues raised by

Hanks in his appeal. Accordingly, it affirmed the lower court's ruling. Justice Robert Brown wrote for the Court:

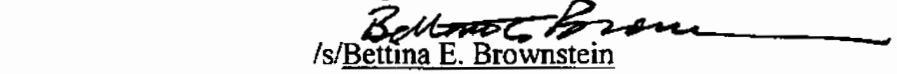
> Again, we do not find where the Board decided the individual issues now raised by Hanks in his appeal. ... It simply made the the statement that the ADH has *complied* with its rules on rendering its decision. Nor did the Board make a finding . . . on alleged constitutional violations such as equal protection or due process violations. According, there is not ruling or order for this court to review, and we will not address these points now. *See Arkansas Contractors Licensing Bd. v. Pegasus Renovation* Co., 347 Ark. 320, 64 S.W.3d 241 (2001) (holding that an appellant must obtain a ruling from the Board in order to preserve an argument, even a constitutional one, for an appeal from an administrative proceeding.

Id.

Just as was the case in *Hanks*, the Board here issued an order which merely states that the Plaintiffs' conduct "fell within the terms of the statute, Ark. Code Ann. § 20-16-1703(d)." Exh. 5. As noted above, the Board further stated that it lacks authority to declare the statute at issue unconstitutional. Exh.5. Respondents' refusal to issue Findings of Fact and Conclusions of Law that comply with the Administrative Procedures Act and Arkansas law, as stated in *Hanks,* would effectively deprive Respondents of their right to judicial review of the agency's decision – a right that is provided for in Ark. Code Ann. § 25-25-212. Respondents know this, as the Board was a party in the *Hanks* case -- where the sufficiency of a very similar Board order was at issue -- yet they refuse to perform their legal duty. Thus, Petitioners have no other means to allow them to comply with *Hanks* and obtain judicial review of the Board's decision, which upholds ADH''s deficiency citations, other than to obtain relief through a writ of mandamus. Under Hanks, Petitioners cannot obtain judicial review of the Board's adverse decision absent an order that complies with the law.

WHEREFORE, Petitioners request that their petition for a writ of mandamus be granted.

Respectfully submitted:



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Attorney for Plaintiffs

On Behalf of Arkansas Civil Liberties Union Foundation, Inc. for Plaintiff Little Rock Family Planning Services

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

BRIEF IN SUPPORT OF APPEALS OF DEFICIENCY FINDINGS AND MOTION TO DISMISS DEFICIENCY CITATIONS

The Basis for the Appeals

Respondents Little Rock Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood of Great Plains ("PPAEO"), submit this brief and motion to dismiss in support of their appeals of deficiency citations contained in a Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 13, 2018 to LRFPS, and Statements of Deficiencies issued to PPAEO's health centers in Fayetteville and Little Rock on March 23, 2018. The grounds for their appeals are:

(1) The statute upon which the citations are based, A.C.A. § 20-16-1703(d), as now interpreted by ADH, ("the Payment Ban"), violates the takings clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 22 of the Arkansas Constitution;

(2) The Payment Ban violates the equal protection clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 18 of the Arkansas Constitution;

(3) The Payment Ban violates the privacy rights of Respondents' patients, as guaranteed by the U.S. and Arkansas Constitutions;

(4) The Payment Ban violates the Contracts Clause of the U.S. Constitution, Art. 1, § 10.

(5) The Payment Ban constitutes tortious interference with contract in violation of Arkansas common law;

(6) ADH exceeded its authority in issuing the deficiency citations absent a regulation or rule prohibiting this conduct, and, under A.C.A. § 20-7-109(c), its interpretation of the law as prohibiting payment for services provided at a patient's first visit until the lapse of 48 hours interferes with the practice of medicine;

(7) Issuance of the deficiency citations was arbitrary and capricious, as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit before the lapse of 48 hours; and

(8) Issuance of the deficiency citations was arbitrary and capricious as PPAEO's practice of gathering credit card information at the first visit and then charging patients for services only after a delay of at least 48 hours complies with A.C.A. § 20-16-1703(d).

Introduction

Passed in 2015, A.C.A. § 20-16-1703(d) prohibits a health center from collecting payment from women for a "service provided in relation to abortion" until the completion of the state's 48-hour mandatory delay before an abortion may be obtained. *The state itself mandates* that clinicians provide certain counseling and ultrasound services, and that they do so at least 48 hours before a patient returns for an abortion. Yet the Payment Ban – contravening uniform standard medical practice – precludes collecting payment for these services at the time they are rendered. Without just compensation, the Payment Ban deprives abortion providers of their state-recognized property interest in their professional earnings. It violates providers' right to equal protection under the law because payment for abortion-related services is singled out for differential treatment from payment for all other medical services, for which patients may be

charged at the time the services are provided. In addition, the Payment Ban erodes Respondents' ability to keep their patients' most intimate, medical information private and violates the contractual relationship between providers and patients. ADH exceeded its authority in issuing the deficiency citations and its actions in doing so were arbitrary and capricious. And for PPAEO, the deficiency citation is unlawful for the additional, independent reason that its practice of collecting credit card information at the first visit, but not charging patients until after expiration of the mandated period, fully complies with the statutory text. For these reasons and others listed above and discussed below, Respondents urge the ADH Board of Health to grant their motion to dismiss the deficiency citations.

Statutory Context

As part of the state's informed-consent mandate, a woman seeking an abortion must receive counseling, have an ultrasound to determine whether there is embryonic or fetal cardiac activity, and receive state-mandated informational materials. § 20-16-1703(b)(1). The counseling must be provided in person at least 48 hours before the abortion, thus legally mandating that a woman make two trips to the providing facility. *Id.* In practice, the ultrasound is also performed at this initial visit so that, among other things, the physician can provide the information required by the mandatory counseling statute. *See* Affidavit of Lori Williams, Exh. 1, Brief and Affidavit of Melany Helinski, Exh. 2, Brief. As further detailed below, Respondents had historically charged patients for the services provided at the first visit and then, if the patient returned for an abortion after the expiration of the 48-hour delay, Respondents charged patients at that time for the abortion. However, according to A.C.A. § 20-16-1703(d), a physician "shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 48-hour reflection

period required in this section." As interpreted by ADH, that means that Respondents are prohibited from collecting payment for services provided at the first visit until the expiration of the 48-hour mandatory delay period. But, for a number of reasons, some women do not return again after the burdensome 48-hour mandatory delay.[1] This means that the Payment Ban impedes Respondents' ability to *ever* recover fees for first-visit services from those women who do not return, resulting in a significant financial loss to Respondents.

Failing to comply with the provision subjects a physician to criminal prosecution, civil penalties, findings of unprofessional conduct, and license suspension or revocation. §§ 20-16-1709, 1710. The Payment Ban forces abortion providers either to risk their patients' constitutionally protected privacy rights by attempting to contact them by telephone and/or sending them paper bills in an attempt to recover the fees for services provided at the first visit, or to forego payment entirely for these services. *See* Exhs. 1 and 2. The Payment Ban thus serves only to undermine patients' trust that they can receive high-quality care without having to sacrifice their privacy.

Procedural History

LRFPS received a Statement of Deficiencies from ADH on March 13, 2018, which stated that LRFPS was in violation of A.C.A. § 20-16-1703(d). PPAEO's health centers also received letters from ADH on March 13, 2018, seeking additional information about PPAEO's collection of credit card information (but not payment) on a patient's first visit for those first-visit services. It was unclear from these letters whether ADH had determined that PPAEO's practice of

[1] A woman may not return for the second visit because of the many logistical and financial barriers associated with Arkansas's mandate that she make a second trip to the facility such as: travel costs (particularly if she is travelling a far distance), the need to arrange child care, the need to take additional time off from work, the need to keep the abortion private from others, among other barriers. *See* Exhs. 1 and 2

collecting credit card information complied with the law. Then, on March 23, 2018, ADH sent revised letters to PPAEO Little Rock and Fayetteville health centers clarifying that it considered the collection of credit card information a deficiency and violation of the law.

Within the 10-day allowed period, Respondents disputed the legitimacy of the citations and requested a hearing before the Arkansas Board of Health ("the Board"), in accordance with A.C.A. § 20-15-208. Respondents have agreed to a joint hearing on their administrative appeals of the citations.

Respondents' Medical and Billing Procedures

Consistent with widespread medical practice, Respondents historically charged patients for first-visit services at the time those services were provided. After passage of A.C.A. § 20-16-1703(d), LRFPS continued this practice, which approach was validated when, following an inspection by ADH in 2016, it was found in compliance with all applicable ADH rules and regulations and was not cited for any violation of § 20-16-1703(d). *See* Exh. 1. On July 14, 2016, ADH again inspected LRFPS. Following this inspection, ADH issued a Statement of Deficiencies citing violation of §20-16-1703(d) as the basis for a deficiency citation. After an appeal, ADH subsequently dismissed the citation, agreeing with LRFPS that ADH lacked authority to issue it because it had no authority over physician conduct and there was no rule or regulation covering the particular conduct involved. *See* Exh. 1.Therefore, LRFPS continued charging for first-visit services at the time provided until it received the deficiency citation that is the subject of its appeal.

Following passage of § 20-16-1703(d), PPAEO initially ceased charging patients for any first-visit services at the time of the first visit. But due to the financial losses, PPAEO experienced as a result of not charging patients at the time of the first visit, PPAEO instituted the

practice of obtaining credit card information from the patient at the time of the first visit, but not submitting any credit card charges until (at the soonest) the expiration of more than 48 hours. *See* Exh. 2. Collecting credit card information at the first visit but not charging patients until after the expiration of the 48-hour period is consistent with A.C.A. § 20-16-1703(d), which provides only that a provider "shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section."

Since the deficiency citations were received that are the subject of this appeal, Respondents have refrained from charging for services or obtaining credit card information from patients at the time of the first visit. *See* Exhs. 1 and 2. Instead, if patients do not return for a second visit to obtain an abortion, have indicated they do not intend to obtain an abortion, or are otherwise ineligible for an abortion, Respondents send them an invoice by mail after at least 48 hours have passed, and attempts – often unsuccessfully – to obtain payment in this manner. *See* Exhs. 1 and 2. On occasion, if the patient has expressed concern about receiving mail, PPAEO will attempt telephone contact – also after the expiration of at least 48 hours. *See* Exh. 2. If a patient does return for her abortion, she is then charged for the medical services rendered at both visits. *See* Exhs. 1 and 2. In no instance, at the present time, is payment requested by either Respondent for services provided at the first visit prior to the elapse of 48 hours. *See* Exhs. 1 and 2.

Respondents' First-Visit Services

At all times, both before and after the issuance of the deficiency citations, during the first visit to LRFPS or PPAEO, a woman is given information in accordance with § 20-16-1703. A patient who desires an abortion then undergoes an ultrasound administered by qualified staff and

interpreted by physicians. The ultrasound determines the location of pregnancy (intrauterine or ectopic), how many weeks the pregnancy has advanced, whether the pregnancy is ongoing, and whether there is embryonic or fetal cardiac activity. (If the pregnancy is not ongoing, the woman may receive immediate medical care to manage her pregnancy loss, or a referral to a medical provider of her choice.)

The ultrasound is necessary at the first visit to comply with state-mandated requirements including (1) to determine whether there is embryonic or fetal cardiac activity, and, if so, to inform the patient of that fact, A.C.A. § 20-16-1303; (2) to inform the patient of how many weeks the pregnancy has advanced and of the "probable anatomical and physiological characteristics of the" embryo or fetus, *id.;* § 20-16-1703(b)(1)(C-D); and (3) to describe "the proposed abortion method," *id.*; § 20-16-1703(b)(1)(B)(i). State law mandates that the physician provide this information, which is dependent on ultrasound, at least 48 hours before the abortion. *Id.;* § 20-16-1703(b)(1); *See* Exhs. 1 and 2. A provider who fails to comply with these mandates would face criminal charges, civil liability, and termination of his or her medical license. §§ 20-16-1709, 1710.

Inasmuch as state law requires an abortion patient to travel twice to a clinic, at least 48 hours apart, providing the ultrasound at the first visit also reduces the risk that a patient will have to return unnecessarily – and suffer further delay – if the ultrasound reveals that she is not eligible for an abortion at that clinic if, for example, her pregnancy has advanced beyond the point that that clinic provides abortion care. *See also fn. 1.*

If there are any signs of an ectopic pregnancy, the woman is referred on an urgent basis for additional care. If the woman has an intrauterine pregnancy, is within the period of pregnancy during which the health center provides abortions, and desires an abortion, a licensed

nurse under the direction of a physician and a physician provide the information the state mandates for the woman to be able to give informed consent for an abortion.

Payment for Services at LRFPS and PPAEO

At LRFPS, prior to March 13, 2018, payment for the ultrasound, lab work, and mandated informed consent counseling was obtained at that visit. If the patient returned for an abortion, she was charged at that time for her abortion care. *See* Exh. 1. Since the deficiency was issued on March 13, 2018, if the woman does not return to LRFPS, she is billed by mail via the U.S. Postal Service at the mailing address she provided during her first visit. *See* Exh. 1. The invoice states that payment is due upon receipt. If no payment is received, the patient is billed once again after an additional 30 days. *See* Exh. 1.

At PPAEO, prior to the passage of A.C.A. § 20-16-1703(d), PPAEO patients were charged at the first visit for the ultrasound, lab work, and mandated informed consent counseling, and payment was required that same day. If the patient returned for the second visit to terminate her pregnancy, she was charged for her medication abortion (the only abortion method PPAEO provides). *See* Exh. 2. After passage of A.C.A. § 20-16-1703(d), PPAEO initially did not accept any payment or collect any credit card information at the first visit. Then, beginning in February 2017 through March 23, 2018, PPAEO collected credit card information at the first visit but did not process the information until the patient's pregnancy had progressed past the range for a medication abortion, or the patient had affirmatively stated she did not plan to have an abortion at a PPAEO health center, and always at least 48 hours after the first visit. *See* Exh. 2. Generally, significantly more than 48 hours was allowed to pass to give the patient an opportunity to return for the abortion. In the majority of cases, the credit card charges did not go through when PPAEO attempted to process the credit card, and PPAEO then attempted to collect

payment by sending the patient a hard copy bill. *See* Exh. 2. Since March 23, 2018, PPAEO has not collected any payment or credit card information prior to the lapse of 48 hours after the patient's first visit. If a patient returns for her abortion, at that time she is billed for both her procedure and her first-visit services. If a woman does not return for the abortion, PPAEO mails a hard copy bill to the patient for the first-visit services. a *See* Exh s 2

The Evidence

The evidence contained in Exhibits 1-3 shows that LRFPS and the PPAEO have experienced significant loss of revenue as a result of ADH's current interpretation of § 20-16-1703(d) as prohibiting payment at the first visit for physician charges for ultrasounds and other first-visit services. From February 1, 2017 to March 22, 2018, PPAEO lost $10,961.66 in patient revenue. *See* Affidavit of Nathan Johnson, Exh.3, Brief. Fifty-seven women did not return for an abortion and have unpaid balances[2] for this period. LRFPS had a loss of $20,000 in patient revenue from March 1, 2018 to September 5, 2018. *See* Exh.1.One hundred and two patients who did not return for an abortion and who were billed for first visit services during this same period, did not pay for these services. *See* Exh. 2.

The evidence shows that, based upon Respondents' experience, this rate of payment delinquency is not unexpected and is the reason why most medical providers charge for services on the same day they are received. Insurance or other third-party payment is not available for ultrasounds and the other first-visit services; thus, the only means to ensure payment for these physician and other professional services is to charge a patient before the service is provided. *See* Exhs. 1-3. In addition to the loss of revenue from patients, Respondents incur additional

[2] As of the date of this motion and brief, PPAEO, due to the intermittent nature of the paper billing, is unable to ascertain its total lost revenue since it ceased collecting credit card information on March 24, 2018.

expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if not for the Payment Ban. These additional expenses are estimated at $540 for LRFPS. *See* Exh. 1. There is an additional expense for PPAEO associated with attempts to collect payment by paper billing. *See* Exh. 3.

No health care provider in the state other than an abortion provider is prohibited from charging for services until 48-hours has elapsed. For instance, plastic surgeons, and oral surgeons and dentists, when their services are not covered by insurance, charge for services when rendered. No law prevents them from doing so. *See* Exhs 1-3.

The Payment Ban Is Unconstitutional under Both the Federal and Arkansas Constitutions as a Taking Without Just Compensation

The statutory prohibition on charging for an ultrasound and other first-visit services before the lapse of 48 hours constitutes an unconstitutional takin without just compensation under the Takings Clause of both the Fifth Amendment to the U.S. Constitution (made applicable to the states by the Fourteenth Amendment) and Article 2, § 22 of the Arkansas Constitution. The Fifth Amendment provides that "private property" shall not "be taken for public use, without just compensation." *Chicago, B. & Q.R. Co. v. Chicago*, 166 U.S. 226, 239 (1897); *Penn Central Transportation Company, v. City Of New York*, 438 U.S. 104, 122 (1978).

A legitimate property interest is "determined by reference to existing rules or understandings that stem from an independent source such as state law." *Phillips v. Washington Legal Foundation*, 524 U.S. 156, 163–64 (1998) (internal citation and quotation marks omitted). "[A]t least as to confiscatory regulations (as opposed to those regulating the use of property), a State may not sidestep the Takings Clause by disavowing traditional property interests long recognized under state law." *Id.* at 167 (internal citation and quotation marks omitted).

Government has the authority to confiscate private property, but it imposes two conditions on the exercise of such authority: the taking must be for a "public use" and "just compensation" must be paid. *Brown v. Legal Foundation of Washington*, 538 U.S. 216, 232 (2003). The Arkansas Constitution has a similar provision: " [P]rivate property shall not be taken, appropriated or damaged for public use, without just compensation therefor." Art. 2, Sec. 22.

The Arkansas Supreme Court has decreed that the right to payment for medical services is a property interest protected by both the federal and Arkansas constitutions. In *Arnold v. Kemp*, 306 Ark. 294 (1991), the Court found that a state statute that capped attorneys' fees paid to counsel appointed to represent indigent criminal defendants represented a taking without just compensation under both the Fifth Amendment and Arkansas Constitution and declared the statute unconstitutional. The Court said,

> Attorneys, like the members of any other profession, have for sale to the public an intangible—their time, advice, and counsel. Architects, engineers, physicians, and attorneys ordinarily purvey little or nothing which is tangible. It is their learned and reflective thought, their recommendations, suggestions, directions, plans, diagnoses, and advice that is of value to the persons they serve. It is not the price of the paper on which is written the plan for a building or a bridge, the prescription for medication, or the will, contract, or pleading which is of substantial value to the client; it is the professional knowledge which goes into the practice of the profession which is valuable.
>
> Attorneys are licensed by the state to practice their profession; but so are other professionals, such as architects, engineers, and physicians. One who practices his profession has a property interest in that pursuit which may not be taken from him or her at the whim of the government without due process.
>
> Attorneys make their living through their services. Their services are the means of their livelihood. We do not expect architects to design public buildings, engineers to design highways, dikes, and bridges, or physicians to treat the indigent without compensation.
>
> When attorneys' services are conscripted for the public good, such a taking is akin to the taking of food or clothing from a merchant or the taking of services from any other professional for the public good.

Id. at 301.

The recognition by the Supreme Court of Arkansas that payment for professional services, including professional medical services, is property means that these earnings are protected property interests under both the federal and state constitutions. *See Phillips v. Washington 524 U.S. at 163–64; Burns v. Brinkley*, 933 F. Supp. 528, 532 (E.D. N.C. 1996). The Court in *Burns* explained that the U.S. Constitution looks to state law to determine what constitutes a protected property right. *Id.* (citing *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 538 (1985)). Thus, payments for the medical services provided by Respondents are protected property rights that cannot be abrogated under either the U.S. or Arkansas constitutions absent just compensation.

The evidence shows that banning payment at the time of a patient's first visit to Respondents means that their physicians and other licensed staff are forced to provide services without compensation. *See* Exhs 1-3. Just as requiring the attorneys in *Arnold v. Kemp* to provide services without compensation was an unconstitutional takings in violation of both the federal and state constitutions, forcing Respondents and their physicians to perform certain services in order to comply with the law and then making them forgo compensation for these services is also an unconstitutional taking without just compensation.

In addition, there is no evidence that banning payment for 48 hours furthers any public purpose or use. The only evidence of any purpose behind the enactment of §20-16-1703(d) is contained in Act 1086, codified at § 20-16-1709, "Legislative finding and purposes." *See* Act 1086, Exhi. 4 to Brief. An examination of these findings and purposes shows that all are concerned with ensuring that a woman possess adequate information to make an informed decision as to whether to terminate her pregnancy. The Payment Ban has no impact on this. The

evidence shows that a woman receives the same information prior to giving informed consent (or not), irrespective of the timing of payment. *See* Exhs. 1 and 2. In the absence of any public purpose whatsoever for taking Respondent's protected professional earnings, the Payment Ban is unconstitutional and should be invalidated.

The Payment Ban Violates the Equal Protection Provisions of the Federal and Arkansas Constitutions

The Equal Protection Clause of the Fifth Amendment is "essentially a direction that all persons similarly situation should be treated alike." *Stevenson v. Blytheville School Dist. #5,* 800 F.3d 955, 970 (8th Cir, 2015) (quoting *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985)) (internal quotation marks omitted.) The Equal Protection Clause of the Fourteenth Amendment states in pertinent part, " . . . nor shall any state . . . deny to any person within its jurisdiction the equal protection of its laws."

The Arkansas Constitution imposes a similar requirement. Article 2, Section 3 of the Arkansas Constitution states, "The equality of all persons before the law is recognized and shall ever remain inviolate; . . ." Article 3, Section 18 of the Arkansas Constitution states, "The General Assembly shall not grant to any citizen, or class of citizens, privileges or immunities which, upon the same terms, shall not equally belong to all citizens."

Under both the federal and Arkansas Constitution, while most laws may survive an equal protection challenge "if the distinction it makes rationally furthers a legitimate state purpose," *Zobel v. Williams,* 457 U.S. 55, 60 (1982), the state may not rely on a classification "whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne,* 473 U.S. at 446; *see Streight v. Ragland,* 280 Ark. 206, 213 (1983) (noting

that the same rational basis review applies to equal protection arguments raised under both the Arkansas and federal constitutions).[3]

The Payment Ban penalizes abortion providers and no other health care professionals, for no legitimate reason, much less a constitutionally-sufficient one. There is no other instance where the state forces a doctor to perform certain services, mandates the timing of those services, and then effectively disallows payment for those services. Because the law singles out abortion providers for disparate treatment without justification, it is unconstitutional under both the federal and Arkansas constitutions. *See Arnold v. Kemp* 306 Ark. 294, 304 (1991).

In *Arnold*, the Arkansas Supreme Court found that singling out certain attorneys to provide services to the indigent at a reduced rate of compensation violated the equal protection guarantees of the federal and Arkansas constitutions. In making this determination, the Court considered three factors: (1) the character of the classification, (2) the individual interests asserted in support of the classification, and (3) the governmental interests asserted in support of the classification. *Id.* It concluded that the burden to represent the indigent fell impermissibly on a subclass of attorneys. The Court found there was no rational basis for the disparate treatment, rejecting the state's argument that since only lawyers had the requisite license to practice law, the legislature "could take one step at a time in addressing complex problems." *Id.* Instead, the Court found that the legislature could not infringe upon the guaranteed constitutional rights of the citizens it represents, and that the burden to represent the indigent fell unequally on different lawyers. Therefore, lawyers' rights to equal protection were violated. *Id.* Just as was the case with the lawyers in *Arnold*, the Arkansas Legislature is impermissibly infringing on the

[3] Actually, the appropriate level of scrutiny to apply in these appeals' challenge under equal protection is heightened scrutiny, since the Payment Ban targets a woman's fundamental right to an abortion.

guaranteed constitutional rights of the citizens it represents, in this case abortion providers—and only abortion providers –are forced to render professional services without compensation. There is no rational basis for this punitive law, nor is there any reasonable relationship between the law and any purported purpose. While rational basis review does not "require a perfect or exact fit between the means used and the ends sought," *Walker v. Hartford Life & Accident Ins, Co.*, 831 F. 3d 968, 978-79 (8th Cir. 2016), it is "not toothless." *Kansas City Taxi Cab Drivers Ass.n LLC v. City of Kansas City, Mo.*, 742 F. 3d 807, 810 (8th Cir. 2014). Instead, equal protection review requires, at a minimum, that a statute's discriminatory line-drawing be rationally related to a legitimate state need. And here, the evidence shows no such relationship. There is simply no medical or other legitimate justification for prohibiting a physician from charging for services rendered to a patient at the time of service. Rather, the Payment Ban effectively prevents physicians who provide abortion from obtaining compensation for medical services they deliver – even though these medical services are mandated by Arkansas law. *See* Exh. 3. Indeed, the law appears motivated by animus toward abortion. Such motivation cannot provide a rational basis for denying compensation to abortion providers and no other type of health care provider.

The lack of a legitimate purpose for the Payment Ban is borne out by the only evidence of legislative intent behind this law, as discussed above. *See* Exh. 4. An examination of these findings and purposes shows that all are concerned with ensuring that a woman possess adequate information to make an informed decision as to whether to terminate her pregnancy. That purpose has no rational relationship to the Payment Ban: whether a woman receives the information to make an informed decision is not influenced by when payment for services already rendered is made. *See* Exhs 1 and 2. And, regardless of whether a woman obtains an abortion, she remains liable for payment for these first-visit services. Requiring delayed payment

for first-visit services does nothing to add to the information a woman has prior to her decision. Women receive the same state-mandated information and are required to observe the same 48-hour delay regardless of when payment is made. *See* Exhs 1 and 2. Thus, the prohibition on payment at the first visit does nothing to further any state interest in ensuring that women have sufficient information before choosing to have an abortion. And the state of course does not have a legitimate interest in "taking" a physician's legitimate compensation for services provided. *See* Exh. 4.

The Payment Ban Violates a Patient's Right to Privacy under the U.S. Constitution

The U.S. Constitution protects not only privacy in individual decision-making, but also "the individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977); *see McCambridge v. City of Little Rock*, 298 Ark. 219, 229 (1989) (recognizing a constitutional right to nondisclosure of "personal matters"); *see also Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (holding that the right protects "highly personal matters" in "the most intimate aspects of human affairs"); *Cooksey v. Boyer*, 289 F.3d 513, 515–16 (8th Cir. 2002) (same); *Alexander v. Peffer*, 993 F.2d 1348, 1349–50 (8th Cir. 1993) (same). By threatening disclosure of the identity of women who have sought abortions, the Payment Ban violates patients' constitutional right to informational privacy.

The Payment Ban creates a significant risk that confidential abortion information will be disclosed to third parties. Because of this statute, it is practically impossible to obtain payment for first-visit services from those patients who, for a variety of reasons – such as difficulties arranging transportation to travel (often for long distances), inability to take off from work, inability to arrange childcare, need to keep the abortion private, or being beyond the point in pregnancy at which the clinic provides abortion care – are unable to return for an abortion. *See*

Exhs 1 and 2. Respondents are forced instead to attempt to contact these patients by either telephone or mail to try to recover payment for these services. Both these methods carry significant risk of exposing the patient's visit to a third party. Telephoning presents the risk that other individuals will answer the provider's telephone call or overhear the conversation;[4] mailing a bill carries the risk that someone else will open the envelope with the bill. *See* Exhs. 1 and 2. Both types of communication may thus lead to the disclosure of confidential information that a woman is pregnant and considering an abortion. *See Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1042 (E.D. Ark. 2017) (finding that LRFPS "is a well-known abortion provider," so any communication relating to LRFPS necessarily "discloses that the patient likely is seeking an abortion"). While Respondents make their best efforts to minimize the chances that this personal information is disclosed through the collection process, *see* Exhs. 1 and 2, there remains a significant risk that a woman's confidential medical information will be disclosed. In contrast, if women were able to pay for the services at the first visit, there would be no need to contact these patients after the fact to obtain payment. *See* Exhs.1and 2. In this way the statute impermissibly risks disclosure of the identity of women who sought an abortion but did not return to the provider for the abortion appointment.

The Arkansas Supreme Court has held that the right to informational privacy under the U.S. Constitution protects "personal matters," meaning "information: (1) that the individual wants to and has kept private or confidential, (2) that, except for the challenged government

[4] In addition, telephoning patients about outstanding bills requires additional resources that are unlikely to result in payment since many patients change phone numbers frequently or have phones that are often out of service. *See* Exh. 2.

action, can be kept private or confidential, and (3) that to a reasonable person would be harmful or embarrassing if disclosed." *McCambridge v. City of Little Rock*, 298 Ark. 219, 230 (1989).[5]

A woman seeking an abortion meets all three of the *McCambridge* criteria. It is no secret that abortion can be a highly-charged, emotional issue. *See Jegley*, 267 F. Supp. 3d at 1076. Many patients are desperate not to reveal to anyone that they are pregnant and considering an abortion. *See* Exh. 1 and 2. For some women, disclosure of the fact that they sought an abortion could expose them to abuse. *See Jegley*, 267 F. Supp. 3d at 1076. (finding evidence in the record that "women fear hostility or harassment. . . for deciding to seek an abortion"). There is ample evidence that women who seek abortions in Arkansas are subject to hostility and harassment. *See PPAEO v. Jegley*, 4:15-cv-84, Prelim. Inj. Order (June 18, 2018). Because a woman seeking an abortion typically (1) wants to keep her decision to seek an abortion private, (2) could keep it private but for the Payment Ban, and (3) might be harmed or embarrassed by its disclosure, her abortion decision is a "personal matter" entitled to constitutional protection under Arkansas Supreme Court precedent.

A woman also has a protectable privacy interest in her abortion-related information under U.S. Supreme Court and Eighth Circuit precedent. In the Eighth Circuit, the right to informational privacy applies where disclosure would be "a shocking degradation or an egregious humiliation," or "a flagrant bre[a]ch of a pledge of confidentiality which was instrumental in obtaining the personal information." *Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (quoting *Alexander v. Peffer*, 993 F.2d 1348, 1350 (8th Cir. 1993)). Constitutional

[5] Arkansas state courts are bound by the Arkansas Supreme Court's interpretation of federal law. *See Lockhart v. Fretwell*, 506 U.S. 364 (1993) (Thomas, J., concurring) ("An Arkansas trial court is bound by [the United States Supreme] Court's (and by the Arkansas Supreme Court's and Arkansas Court of Appeals') interpretation of federal law. . . .").

protection turns on "the nature of the material" and whether the person has "a legitimate expectation that the information would remain confidential." *Id.*

The decision to have an abortion "involves some of the most intimate and personal aspects of a woman's life." Jegley, 267 F. Supp. *at* 1095 A woman has a legitimate expectation that information revealed to her physician will remain confidential. *See, e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001) ("The reasonable expectation of privacy enjoyed by the typical patient . . . is that [her medical information] will not be shared with nonmedical personnel without her consent."). As a form of medical information, abortion-related information is a "categor[y] of data which, by any estimation, must be considered extremely personal." *Eagle*, 88 F.3d at 625. The involuntary disclosure that a woman sought an abortion could cause a woman to suffer "a shocking degradation" or "egregious humiliation," *Jegley*, 267 F. Supp. 3d at 1093, in part because of the violence and abuse that might ensue. Accordingly, as the Eastern District of Arkansas recently concluded, abortion information lies at the core of informational privacy under the Eighth Circuit's standard. *See Jegley*, 267 F. Supp. at 1095 (finding a likelihood of success on informational privacy claim based on disclosure of a minor's abortion to local law enforcement).[6] For all these reasons, patients have a strong, constitutionally-protected interest in avoiding disclosure of their sexual activity and their desire to seek an abortion.

A law invading constitutionally-protected privacy can be upheld only if a substantial government interest outweighs the burdened privacy right. *See McCambridge*, 298 Ark. at 231

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[6] *See also Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 553 (9th Cir. 2004) (informational privacy protections triggered by requirement to disclose abortion patient records to state); *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 371 (4th Cir. 2002) (applying informational privacy doctrine to abortion information, but finding no constitutional violation because of adequate "recordkeeping and information reporting mechanisms").

(citing *Nixon v. Administrator of General Servs.*, 433 U.S. 425, 456–57 (1977)); *see also Taylor v. United States*, 106 F.3d 833, 837 (8th Cir. 1997) (concluding "that the government has the requisite interest" in disclosure and that the statute "is sufficiently related to such interest . . . to pass constitutional muster"). The Payment Ban is purportedly designed to ensure a woman's informed consent to an abortion, *see* Exh. 4, but as described at length above, prohibiting providers from collecting payment for services *already* provided—payment for which a woman remains liable *regardless of whether she obtains an abortion, or does so at the same clinic where she received the first-visit services*—does nothing to ensure her informed consent.

In fact, this risk of a "breach of confidentiality" may "interfere with a woman's right to decide to end a pregnancy" and "cause [her] to for[e]go abortion in Arkansas rather than risk disclosure" of the fact that she sought an abortion. *Jegley*, 267 F. Supp. 3d at 1076; *see also Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1462 (8th Cir. 1995) (recognizing the harm of a parental notice statute because "parents who differ from their [minor] daughters on religious or moral grounds over abortion" might go so far as to "prevent their daughters from obtaining abortions"); *Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1061 (D.S.D. 2011) (finding that a woman may choose to forego her abortion rather than disclose her decision to a Pregnancy Help Center). There is no state interest that outweighs this risk, and so the law fails any constitutional balancing and impermissibly infringes on Respondents' patients' constitutional right to informational privacy.

The Payment Ban Also Violates Patients' Right to Privacy Under the Arkansas Constitution

Implicit in the Arkansas Constitution is "a fundamental right to privacy" that triggers strict scrutiny review. *Jegley v. Picado*, 349 Ark. 600, 632 (2002); *see also Zimmerman v. Pope*, 2015 Ark. App. 499 (2015) (applying *Picado*). Recognizing the state's "rich and compelling

tradition of protecting individual privacy," the Arkansas Supreme Court has held that the state constitution provides even *greater* privacy protection than the U.S. Constitution. 349 Ark. at 631. *Picado* contemplates that a statute like the Payment Ban, which "disclos[es] [a woman's] records" and results in "an unwarranted invasion of personal privacy," violates her fundamental right to privacy. 349 Ark. at 631. "When a statute infringes upon a fundamental right, it cannot survive unless 'a compelling state interest is advanced by the statute and the statute is the least restrictive method available to carry out [the] state interest.'" *Picado*, 349 Ark. at 632 (quoting *Thompson v. Arkansas Social Services*, 282 Ark. 369, 374 (1984)). Even if the statute at issue here could survive a lesser balancing test (which it cannot), it certainly could not survive strict scrutiny: the method by which the Payment Ban operates is not just more restrictive than necessary, but *entirely unrelated* to its supposed purpose of ensuring a woman's informed consent. As explained above, a woman remains liable for the bill for first-visit services, *regardless of whether she returns to the same clinic for an abortion*, and so the law does nothing to inform her decision. Because it fails strict scrutiny review, the Payment Ban also violates patients' right to informational privacy under the Arkansas Constitution.

The Statute Violates the Federal Contracts Clause

The Contracts Clause of the federal Constitution provides that "[n]o state shall . . . pass any . . . Law impairing the Obligation of Contracts." U.S. Const., Art. I, § 10, cl. 1. Courts generally apply a two-step test when analyzing a claim under the Contracts Clause. *See, e.g., Gen. Motors Corp. v. Romein*, 503 U.S. 181 (1992). Courts first determine "whether the state law has 'operated as a substantial impairment of a contractual relationship.'" *Id.* at 186. In answering this question, courts consider "whether there is a contractual relationship, whether [the] law impairs that contractual relationship, and whether the impairment is substantial." *Id.* If

there is a substantial impairment of the contractual arrangement, courts then assess "whether the state law is drawn in an 'appropriate' and 'reasonable' way to advance 'a significant and legitimate public purpose.'" *Sveen v. Melin*, 138 S. Ct. 1815, 1822 (2018) (citing *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411–12 (1983)).

In this instance, the evidence shows that the Payment Ban operates to substantially impair the contractual arrangement between the abortion provider and the patient. *See* Exh 1-3. The providers and their physicians stand in a contractual relationship with the individual patient in rendering medical services. The Payment Ban unarguably constitutes a substantial impairment of Respondents' ability to receive compensation under this arrangement. *See* Exhs 1 and 3. More specifically, the Payment Ban interferes with a health care provider's reasonable expectation of payment for professional services, and prevents the health care provider from safeguarding the right to compensation for these services. *See Sveen*, 138 S. Ct. at 1822.

The Payment Ban Tortiously Interferes with Respondents' Contractual Relationships with Their Patients

Arkansas recognizes the tort of interference in situations involving contract or business expectancies between a physician and patient. *See LasikPlus Murphy, M.D., P.A. v. LCA-Vision, Inc.*, 776 F. Supp. 2d 886, 897 (E.D. Ark. 2011) (citing *Baptist Health v. Murphy*, 373 S.W.3d 269, 284 (Ark. 2010)). The elements of tortious interference with contractual rights are: "(1) the existence of a valid contractual relationship or business expectancy; (2) knowledge of the relationship or expectancy on the part of the interferer; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage to the party whose relationship or expectancy has been disrupted." *Walt Bennett Ford, Inc. v. Pulaski Cnty. Special School Dist.*, 274 Ark. 208, 214 (Ark. 1981). These four elements are easily met in this case.

Respondents indisputably enter into valid contractual relationships with individual patients at their initial visit. (1) The parties are competent; (2) there is a subject matter upon which a contract can operate (medical services); and (3) legal consideration, as well as mutual agreement and mutual obligation, are present (medical services rendered in exchange for payment). *See City of Dardenelle v. City of Russellville*, 372 Ark. 486, 490 (Ark. 2008) (listing the "essential elements of a contract" as "(1) competent parties, (2) subject matter, (3) legal consideration, (4) mutual agreement, and (5) mutual obligation"). ADH is aware of this contractual relationship and that Respondents depend on patient fees to pay for the ultrasound and other first-visit services.

Damages result from enforcement of the Payment Ban. *See* Restatement (Second) of Torts § 774A (Am. Law. Inst. 1979) (damages for interference include "the pecuniary loss of the benefits of the . . . prospective relation . . . [and] consequential losses for which the interference is the legal case"). Dr. Thomas Tvedten is the owner of LRFPS, and the loss of patient revenue due to the Payment Ban falls directly to him. *See* Exh. 1. The loss of patient revenue affects the ability of PPEAO's clinics to provide a livelihood to its physicians and professional staff. Exh, 3. LRFPS has experienced a loss of revenue of $20,540 since the issuance of the Statement of Deficiencies, *see* Exh. 1. PPAEO has experienced a loss of $10, 961.66 since February 2017 to March 23, 2018 and more since that date. *See* Exh.3. Because of this interference with Respondents' contractual relationships with their patients and the attendant damages they experience, the Payment Ban should be invalidated.

ADH Exceeded Its Authority in Issuing the Statements of Deficiencies Because There Is No Regulation or Rule Prohibiting the Conduct Cited, and ADH's Current Interpretation of the Statute Impermissibly Regulates the Practice of Medicine

A previous deficiency citation issued by ADH to LRFPS on August 5, 2016 was dismissed after an appeal because there was no Board rule or regulation governing LRFPS's practice of charging patients for an ultrasound and other services at the time the services were provided. Robert Brech, then General Counsel for ADH, recognized that absent such a rule or regulation, ADH lacked the authority to issue the citation. *See* Brech Aug. 25 Letter, Exh. B to Exh. 1. The conduct cited in the March 23, 2018, Statement of Deficiencies is identical to that dismissed previously. However, no pertinent regulation or rule has ever been promulgated by the Board. Therefore, for the same reason the August 5, 2016 deficiency citation was dismissed, the citations that are the subject of these appeals should meet the same fate.

In addition, even if there *were* a rule or regulation on this issue, Arkansas law makes clear that the Board "shall not regulate the practice of medicine or healing nor interfere with the right of any citizen to employ the practitioner of his choice." A.C.A. § 20-7-109. Banning payment for services provided at a patient's first visit until the lapse of 48 hours unquestionably constitutes regulation of Respondents' physicians' practice of medicine. ADH's current interpretation of the statute interferes with both the timing and method of payment by patients (resulting in nonpayment for a significant proportion of services provided). Absent the Payment Ban, Respondents would require payment for first-visit services at the time of service, thus avoiding the loss of revenue due to the delay in billing. Therefore, ADH lacks authority to issue the citations that are the subject of this appeal: no rule or regulation allows the citations, and the citations violate § 20-7-109 (c) in attempting to regulate when and how Respondents can charge for their medical services.

The Issuance of the Statements of Deficiency to LRFPS Was Arbitrary and Capricious

ADH's issuance of the deficiency citations was arbitrary and capricious as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit and before the lapse of 48 hours. *See* Exh. 1. A subsequent deficiency citation was dismissed. *See Exh. 2.* ADH's about-face in its interpretation of the law is unjustified as LRFPS's practice of charging patients at the first visit, which previously was found to be in compliance with ADH's rules and regulations, is identical to its practice subsequently found to warrant a deficiency citation. This fits the very definition of arbitrary and capricious.[7]

Collecting Credit Card Information Does Not Constitute "Requiring" or "Obtaining" Payment and ADH's Citation of this Practice Was Arbitrary and Capricious.

In any event, PPAEO acted lawfully when it collected credit card information from its patients during their first visit to the clinic, so PPAEO's citations must be withdrawn. ADH's citation of this practice was arbitrary and capricious and not supported under Arkansas law. The statute at issue prohibits an abortion provider from "requir[ing] or obtain[ing] payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period" mandated by law. A.C.A. § 20-16-1703(d). Under Arkansas law, the Board must construe this statute "just as it reads, giving words their ordinary and usually accepted meaning in common language." *Arkansas Dep't of Correction v. Shults*, 2018 Ark. 94, 4, 541 S.W.3d 410, 412 (2018). Language that was not included by the legislature will not be read into the statute. *Id.* If the "statute is

[7] BLACK'S LAW DICTIONARY, 112, 224, 8th ed. (1999) "Arbitrary: Founded on prejudice or preference rather than on reason or fact. " "Capricious: Contrary to the evidence or established rule of law."

ambiguous, th[e] court must interpret it according to legislative intent," and the court's "review becomes an examination of the whole act." *Dickinson v. SunTrust Nat'l Mortg. Inc.*, 2014 Ark. 513, 4, 451 S.W.3d 576, 579 (2014).

The plain language of the statute prohibits only "obtain[ing] payment" or "requir[ing] . . . payment" for an abortion-related service during the mandatory delay. Ark. Code § 20-16-1703(d). Three words are at issue here: "obtain," "require," and "payment." Given its most natural meaning, a payment is a transfer of money. *See Pay*, *Merriam-Webster Online Dictionary* (2018), https://www.merriam-webster.com/dictionary/pay ("to make a disposal or transfer of (money)" or "to give in return for goods or service"); *Payment*, *Merriam-Webster Online Dictionary* (2018), https://www.merriam-webster.com/dictionary/payment ("something that is paid"). To obtain a payment is "to gain or attain [it,] usually by planned action or effort." *Obtain*, *Merriam-Webster Online Dictionary* (2018), https://www.merriam-webster.com/dictionary/payment. To require a payment is "to claim or ask for [it] by right and authority" or "to demand [it] as necessary or essential." *Require*, *Merriam-Webster* (2018), https://www.merriam-webster.com/dictionary/payment. By merely takings a woman's credit card information, but not submitting any charges, PPAEO neither obtains nor requires payment.

First, and simply, PPAEO does not improperly "obtain payment" because it does not "gain or attain" any money during the 48-hour delay. Money from the patient's bank account does not transfer to PPAEO until (if the credit card transaction is successful) the moment her card is charged. And second, taking credit card information is not the same thing as requiring payment. If it were, every online retailer with its customers' credit card information on file would have the "right and authority" to "demand [payment] as necessary or essential" at any time. Under the state's reading of the statute, a company like Amazon, which collects users'

credit card information when they sign up for the service, would be "requir[ing] . . . payment" before users even bought their first item. In the same way, an abortion facility has not "require[d]" payment for an abortion-related service unless and until the credit card information collected from the patient has been processed, which does not happen until after the 48-hour waiting period has elapsed. Under the plain text of the statute, collecting credit card information does not constitute "requiring" or "obtaining" payment.[8]

CONCLUSION

For the reasons asserted above, the Statements of Deficiencies should be dismissed and the Motion to Dismiss granted.

Dated: September 6, 2018

Respectfully submitted:

Bettina E. Brownstein (85019)
Bettina E. Brownstein Law Firm
904 W. Second St., Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com

[8] Even if the statute were ambiguous, the legislature's intent was to ensure a woman's informed consent to an abortion. *See* Exh. 4. Because collecting credit card information is unrelated to that purpose, the statute should not be read to prohibit obtaining credit card information.

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

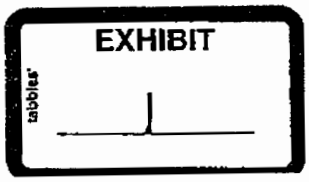
V.

PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Affidavit of Lori Williams

My name is Lori Williams. I am over the age of 21, competent and have personal knowledge of the matters testified to herein.

1. I am currently the Clinic Director at Little Rock Family Planning Services, PLLC ("LRFPS'). I submit this affidavit in support of LRFPS' appeal of the Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 13, 2018.
2. I am an Advanced Practice Nurse with an M.S.N. from Vanderbilt University. From 1999-2000, I worked as a labor and delivery nurse at Rebsamen Medical Center in Jacksonville, Arkansas. In 2000, I was employed at Women's Community Health Center in Little Rock as the nursing supervisor. I also had a gynecology practice. In 2003, I become employed at LRFPS, first as a women's health practitioner, then in 2004 as Associate Clinic Director. In 2007, I became Clinic Director. Thomas H. Tvedten. M.D. is LRFPS's owner and medical director. LRFPS has been in existence since 1973. It is licensed by the State of Arkansas since the 1980s and is in good standing with the Arkansas Department of Health ("ADH"). LRFPS provides abortion care and related services. As Clinic Director, I oversee the day-to-day operation of LRFPS clinic. I



oversee all aspects of patient care under the supervision of Dr. Tvedten. In addition, I participate in all aspects of patient care as needed. I am responsible for management of patient records and all other records kept by LRFPS as mandated by the state and as needed to operate LRFPS. I am also responsible for LRFPS medical record keeping, financial management, and billing practices. In addition, I maintain a separate gynecological practice.

3. On May 16, 2016, LRFPS was inspected by ADH. At that time, the inspectors noted that LRFPS was charging patients seeking an abortion for the ultrasound and other services provided during her first visit prior to providing these services. ADH, however, found that LRFPS was in compliance with all its rules and regulations and did not cite LRFPS for violation of any law, including §20-16-1703(d). Attached as Exhibit A is a true and accurate copy of ADH's May 16, 2016, letter concerning its findings following the inspection. On July 14, 2016, ADH again inspected LRFPS. Following this inspection, ADH issued a Statement of Deficiencies citing violation of §20-16-1703(d) as the basis for a deficiency citation. After an appeal, ADH subsequently dismissed the citation, agreeing with LRFPS that ADH lacked authority to issue it because it had no authority over physician conduct and no rule or regulation covering the particular conduct involved. Attached as Exhibit B is a true and accurate copy of a letter from ADH's General Counsel Robert Brech dismissing the citation.
4. At LRFPS, during a patient's first visit, she is given information as required by law, and an ultrasound is performed by a certified sonographer. The ultrasound determines location of pregnancy (intrauterine or ectopic) whether the pregnancy is ongoing, the gestational age, and whether there is a fetal heartbeat. If an ectopic pregnancy is

suspected, the woman is referred on an urgent basis for additional care. If the pregnancy is not ongoing, the patient is offered miscarriage management or referral to the provider of her choice.

5. If the pregnancy is intrauterine and within the gestational range during which LRFPS provides abortions (21.6 weeks), and if the patient indicates she wishes to return to terminate her pregnancy, she is provided the information the state mandates that she receive in order to give informed consent 48 hours later. The informed consent is done by both a licensed nurse under the direction of a physician and a physician. All ultrasounds are interpreted by a physician using his education, training and experience to determine the patient's eligibility for an abortion and if eligible, to determine the best course of treatment for the patient.
6. The ultrasound is necessary at the first visit to comply with state-mandated requirements including 1) to determine whether there is a fetal heartbeat, and, if so, to inform the patient of that fact; 2) to inform the patient of how many weeks the pregnancy has advanced and of the probable anatomical and physiological characteristics of the embryo or fetus; and 3) to describe the method of the abortion the woman will obtain. State law mandates that the physician provide this information, which is dependent on an ultrasound, at least 48 hours before the abortion
7. But for Arkansas law, LRFPS would provide care all in one day for patients who request it: ultrasound, counseling and, abortion. The only reason to perform the ultrasound 48 hours in advance of an abortion is to comply with Arkansas's mandate that a woman receive certain information and then delay at least 48 hours before she may obtain an abortion. There is no medical reason why the ultrasound must be performed 48 hours in

advance of an abortion. However, because Arkansas mandates that delay, doing the ultrasound at the first visit reduces the risk that a patient will have to return unnecessarily – and suffer further delay – if the ultrasound reveals that she is not eligible for an abortion at the LRFPS clinic. That occurs, for example, if her pregnancy has advanced beyond the point at which we provide abortions.

8. Prior to receiving the deficiency citation that is the subject of this administrative appeal, patients were charged $200 for the ultrasound and the other services provided at the first visit, and payment was required either by cash or credit card before the ultrasound was performed.

9. On January 30, 2018, ADH inspectors visited LRFPS; subsequently, ADH cited the clinic for violation of § 20-16-1703(d) for charging patients prior to the lapse of 48 hours after the first visit. The letter citing LRFPS was received March 14, 2018.

10. Since this latter date, LRFPS has ceased charging patients for the ultrasound described above at the first visit. If a women returns for an abortion, at that time she is charged either by credit card or cash for the amount of the ultrasound, the other initial services, and the abortion.

11. After receiving the services at their first visit, some women do not return to LRFPS for an abortion. This happens for a number of reasons. One common reason is that a woman cannot manage to travel back to our clinic: many of our patients struggle with poverty and have to travel from far away. Transportation, childcare, and work obligations are all problems. The state requirement that they make the trip twice to get an abortion is an insurmountable obstacle for some patients. Other women are beyond the point in

pregnancy at which we offer an abortion; if they are able to travel and desire a referral for abortion out of state, we provide such a referral.

12. If the woman does not return for an abortion within 30 days, LRFPS mails an invoice to the patient at the address she supplies at the first visit. The invoice requests immediate payment. If payment is not received within 30 days, a copy of the original is mailed again to the patient.

13. Based upon my experience, patients are often desperate to keep private their decision to inquire about an abortion. This is for a variety of reasons but often is because family members, including the woman's sexual partner, may have intensely negative feelings about abortion. Many women request that they be allowed to pay at the first visit.

14. LRFPS has considered contacting patients who do not return for an abortion by telephone to advise them that payment for the ultrasound and other services is due and to request payment in lieu of sending an invoice by mail. However, LRFPS staff has determined that the risk of invading patients' privacy by telephoning is greater than that of mailing an invoice. These risks include that someone other than the patient will answer the telephone and want to know from the patient the source and content of the call, or may overhear the patient speaking to us and glean information about the patient's visit to the clinic as a result.

15. I have concerns, based on my experience, that mailing a bill for the ultrasound to the patient's address does pose the risk that someone other than the patient will open the envelop and discover the visit to LRFPS. I have had experience with the privacy problems posed by mailing invoices. In one instance, I mailed an invoice to a patient and someone other than the patient called to inquire why the patient had visited the

clinic. While I do believe that mailing a bill as opposed to telephoning a patient carries less risk of violating her privacy, both involve risks which can be avoided by permitting LRFPS to charge at the point services are provided.

16, Because of the same privacy concerns for abortion patients, LRFPS does not utilize the services of third-party collection services. This further limits our ability to obtain payment.

17. Since March 14, 2018, the day after receipt of the Statement of Deficiencies to the date of this affidavit, 108 patients, who did not return for an abortion, were billed. Of these six patients have paid for their ultrasound and other services after receiving a bill. This has resulted in a total loss of $20,000 to LRFPS and Dr. Tvedten over this period. This loss will increase so long as § 20-16-1703(d) is in effect.

18. In addition to the loss of revenue from patients, LRFPS incurs additional expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if § 20-16-1703(d) were not in effect as now interpreted by ADH. These additional expenses are $540 for 30 additional hours of staff time. These additional staff expenses will increase as long as this law is in effect. Thus, the total loss to LRFPS from March 14, 2018 to the date of this affidavit is $20,540.

19. Based on my experience as Clinic Director it is necessary to collect payment up front from patients as this is the only way to ensure payment for physician services rendered. In my experience, it is standard medical practice to charge at the time services are rendered unless they will be reimbursed by a third party.

20. I am unaware of any other medical provider who is prevented by the state from charging when a service is provided except in the case of an emergency.

21. The same medical and other services are provided to patients irrespective of when we collect payment for these services. Patients receive exactly the same information and receive the same informed consent counseling regardless of the timing of payment.

22. LRFPS relies on payment from its patients to fund the operation of its clinic and to provide its doctors and staff with a livelihood. Dr. Tvedten, as the sole owner of LRFPS, is the recipient of revenue generated by patient fees.

FURTHER AFFIANT SAYETH NOT

Lil Williams 9/5/18

BRITTNEY CAMP
MY COMMISSION # 12399627
EXPIRES: October 8, 2022
Pulaski County

Brittney Camp 9/5/18

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

May 16, 2016

Lori Williams, Administrator
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

RE: Licensure Abortion Clinic Complaint Survey
Conducted 05/12/2016

Dear Ms. Williams:

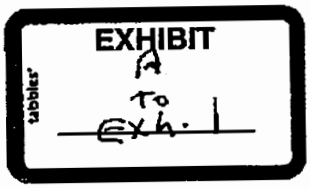
Little Rock Family Planning Services, PLLC is considered to be in compliance with applicable provisions of the Rules and Regulations for Abortion Clinics in Arkansas. We appreciate the cooperation of the Facility staff during the survey.

If we may be of assistance at any time, please call (501) 661-2201.

Sincerely,

Liz Davis, Program Manager
Health Facility Services
Arkansas Department of Health

/sm



Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204-1704 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

August 25, 2016

Ms. Bettina E. Brownstein, Attorney at Law
904 West Second Street
Little Rock, AR 72201

RE: Little Rock Family Planning/Dispute of Deficiency Finding

Dear Bettina:

Thank you for your August 17, 2016, letter disputing the deficiency citation issued to Little Rock Family Planning Services on August 5, 2016, in the Department's Statement of Deficiencies. You have made a number of legal arguments as to why the deficiency citation was improper. Specifically, the deficiency dealt with the facility accepting payments for services provided in relation to an abortion prior to the expiration of the forty-eight hour reflection period as required under Ark. Code Ann. § 20-16-1703(d).

I cannot disagree with your point that the Arkansas Department of Health lacks authority to issue this particular deficiency citation. I also agree that no Board of Health rule or regulation covers this particular conduct. Having determined that your first two points have merit, and my agreement that the Department lacked sufficient authority to issue the citation, I see no reason to address your additional legal arguments. I will instruct the Department staff to retract their deficiency citation. I do expect the staff will forward their findings to the State Medical Board for their consideration.

Sincerely,

Robert Brech, JD
General Counsel

RB/nc

cc: Connie Melton, Branch Chief, Health Systems Licensing
Renee Mallory, Center Director, Health Protection

EXHIBIT B
to
Exh. 1

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

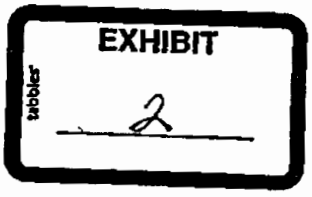
LITTLE ROCK FAMILY PLANNING SERVICES and

PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Affidavit of Melany Helinski

My name is Melany Helinski. I am over the age of 21, competent and have personal knowledge of the matters testified to herein.

1. I am currently the Regional Director of Health Services at Planned Parenthood of Arkansas and Eastern Oklahoma ("PPAEO"). I have been Regional Director since 2013. As Regional Director of Health Services, I am responsible for all health and operational services at all PPAEO health centers in Oklahoma and Arkansas.
2. I submit this affidavit in support of PPAEO's appeal of the Statements of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 23, 2018 to PPAEO's Fayetteville Health Center and PPAEO's Little Rock Health Center, respectively. That statement was issued following letters dated March 13, 2018, in which ADH sought additional information about PPAEO's billing practices after an on-site inspection, and did not state whether a deficiency had been issued. ADH subsequently withdrew these initial letters and clarified that it considered PPAEO's practice, as described below, a deficiency in violation of state law.



developing and implementing all its medical policies and procedures utilized at the Fayetteville and Little Rock health centers.

6. The Fayetteville and Little Rock health centers provide medication abortions. During a patient's first visit, she is given written information in accordance with state law. She is provided information about both medication and surgical abortions, an ultrasound is performed by a nurse practitioner to determine whether the pregnancy is intrauterine and ongoing, how far the pregnancy has advanced, and whether there is embryonic or fetal cardiac activity. If an ectopic pregnancy is suspected, the women is referred on an urgent basis for additional care. If the pregnancy is not ongoing, the patient is offered miscarriage management or referral to the provider of her choice. If the pregnancy is intrauterine and within the period of pregnancy during which PPAEO provides abortion care (up to 10 weeks as dated from the first day of the woman's last menstrual period ("LMP")) and the patient indicates she wishes to return to terminate her pregnancy, she is provided the information the state mandates that she receive in order to give informed consent 48 hours later. Information required for informed consent is provided by both a licensed nurse under the direction of a physician and by a physician. All ultrasounds are interpreted by a physician using his or her education, training and experience to (1) determine the patient's pregnancy status, (2) guide the state's mandated information that must be communicated to the patient, e.g., how many weeks the pregnancy has advanced, and the type of procedure that will be used to terminate the pregnancy, and (3) determine the patient's plan of care, eligibility for an abortion and if eligible, to determine the best course of treatment for the patient.

10. After their first visit, some women do not return for an abortion. This happens for a number of reasons. One common reason is that a woman cannot manage to travel back to our health centers: many of our patients struggle with poverty and have to travel from far away. Transportation, childcare, and work obligations are all problems, especially for a large number of our patients who are poor and have to travel a long distance. The state requirement that they make the trip twice to get an abortion is hugely difficult for some patients. Since we only provide abortion through ten weeks LMP, other women are beyond the point in pregnancy at which we offer an abortion (or will be beyond this point by the time they can get back to our health centers); if they desire a referral for abortion to another provider who may offer an abortion for a longer period of pregnancy, we provide such a referral.

11. After § 20-16-1703(d) went into effect, PPAEO stopped charging for the day one visit until after expiration of the 48-hour period. PPAEO experienced a loss in revenue because of the delayed charging, and I participated in conversations around that time regarding ways to mitigate the financial losses experienced at the health centers; however, the exact data regarding financial losses experienced during that time is difficult to recreate because we merged our old record system with a new system in January 2017. In order to try to reduce its financial losses from being unable to charge for the day one services at the time of the day one visit, in February 2017, PPAEO began collecting credit card information at the first visit, but did not submit any charges for those patients who did not return for the second visit until the patient's gestation was out of range for a medication abortion. PPAEO did not submit charges less than 48 hours after the first visit in any circumstances. In the vast majority of cases, more than 48

related to their abortion. Similarly, some patients express concern when providing PPAEO with their address that nothing be mailed to their address. Other patients express a concern about being contacted by PPAEO about their abortion services by phone. Unfortunately, because of this law, we are unable to collect payment at the first visit even for those patients who affirmatively request to pay for the services at the first visit because of a desire to limit additional communications related their abortion services. Because of the same privacy concerns for abortion patients, PPAEO does not currently utilize the services of third-party collection services. This further limits our ability to obtain payment for the services we provided.

19. For those patients who affirmatively express concern about receiving mail related to their abortion, PPAEO will attempt to notify them about the outstanding balance through an alternative method, such as by phone. Contacting patients by phone about outstanding bills is challenging for multiple reasons: (1) some of our patients do not have working cell phones or land-line phones, or these numbers change frequently, which makes it difficult to contact them by phone; (2) some of our patients share cell phones or land-line phones with others, making it difficult for us to use this as a method of contacting patients about confidential medical services; and (3) we do not have the internal staff resources to follow up with these patients about outstanding bills by phone, particularly given that reaching a patient may take multiple attempts due to the factors detailed above. Thus, contacting these patients by phone (and indeed, any method of contacting patients after the fact to request payment for services provided) is both an unreliable way of

obtaining payment for the services we provided, and problematic for patient confidentiality as it poses a risk that this information will be disclosed.

20. In addition, I believe there are many additional patients who do not affirmatively state a concern with receiving mail at their address, but who nevertheless may be unable to keep their abortion confidential as a result of receiving a paper invoice for abortion-related services. I therefore have concerns, based on my experience, that contacting our patients after the fact to obtain payment for the ultrasound and other services poses a risk that a woman's abortion will be disclosed.

21. The same medical and other services are provided to patients irrespective of the timing of the request for payment for these services. Patients receive exactly the same information and receive the same informed consent counseling regardless of the timing of the payment for these services.

22. PPAEO relies on payment from its patients to funds the operation of its Fayetteville and Little Rock health centers and to cover the salaries of its doctors and staff.

FURTHER AFFIANT SAYETH NOT.

Melany Helinski

State of Oklahoma)
County of Tulsa)

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

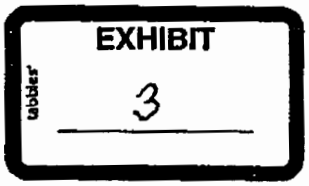
V.

LITTLE ROCK FAMILY PLANNING SERVICES AND PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Affidavit of Nathan Johnson

My name is Nathan Johnson. I am over the age of 21, competent, and have personal knowledge of the matters attested to in this affidavit.

1. I am the Chief Financial Officer ("CFO") for Planned Parenthood of Arkansas and Eastern Oklahoma. I submit this affidavit on behalf of PPAEO in its appeal of the Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 23, 2018 to the PPAEO Fayetteville and Little Rock health centers.
2. As CFO, I am responsible for overseeing the collection, maintenance, and analysis of all financial records generated by the two health centers. In this capacity and in the ordinary course of business, I routinely gather data pertaining to the number of abortions performed at each health center, number of patients who were seen for ultrasounds and counseling, and other services (hereinafter "first day services"), and the timing, method, and amount of payments for services. To prepare this affidavit, I reviewed data stored in PPAEO's electronic health records system concerning patient visits and payments.
3. The PPAEO Fayetteville and Little Rock health centers have experienced significant loss of revenue as a result of § 20-16-1703(d)'s prohibition on obtaining payment for charges for ultrasounds and other medical services performed during a woman's first visit until



limited cases, providers have agreed to accept subsequent insurance payments or allowed patients to establish payment plans. In either of those cases, of course, the decision not to require same-day payment was the result of a provider's choice to enter into a particular payment arrangement, not due to a state or federal requirement.

7. Based on my own experience working with the finances of multiple health care organizations, it is widely known that outstanding fees become increasingly more difficult to collect as more time passes from the date of service.

8. Patient revenue is crucial to PPAEO's ability to continue to operate both the Fayetteville and Little Rock Health Centers and to compensate the physicians and other professional staff for their services. The loss of revenue due to § 20-16-1703(d) is significant in terms of the Fayetteville and Little Rock health centers' ability to cover their operating expenses in the future.

FURTHER AFFIANT SAYETH NOT.

Nathan Johnson

State of Kansas)
County of Johnson)
SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 8/17/2022.

Leanne Mayer
Notary Public

LEANNE MAYER
My Appointment Expires
August 17, 2022

(Seal or Stamp)

Stricken language would be deleted from and underlined language would be added to present law.
Act 1086 of the Regular Session

State of Arkansas *As Engrossed: H3/23/15*
90th General Assembly **A Bill**
Regular Session, 2015 HOUSE BILL 1578

By: Representatives Lundstrum, Bentley, Copeland, Cozart, Davis, Dotson, Eads, C. Fite, Gates, M. Gray, Harris, Henderson, Lemons, D. Meeks, Miller, Payton, Petty, Rushing, B. Smith, Speaks, Sullivan, Vaught, Womack, *Ballinger, Brown, G. Hodges, J. Mayberry, Wallace*
By: Senators J. Hendren, B. Johnson, Files, Hester, *D. Sanders*

For An Act To Be Entitled

AN ACT TO REPEAL AND REPLACE THE WOMAN'S RIGHT TO KNOW ACT OF 2001; TO PROVIDE FOR VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION; TO PROVIDE PROCEDURES FOR ENSURING VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION; TO REQUIRE CERTAIN SIGNAGE IN ABORTION FACILITIES; TO PROVIDE FOR CERTAIN REQUIREMENTS OF THE DEPARTMENT OF HEALTH AND HOSPITALS RELATIVE TO ABORTION; TO PROVIDE FOR THE DELIVERY OF CERTAIN INFORMATION UNDER THE WOMAN'S RIGHT TO KNOW LAW; TO PROVIDE FOR PENALTIES; AND FOR OTHER PURPOSES.

Subtitle

TO REPEAL AND REPLACE THE WOMAN'S RIGHT TO KNOW ACT OF 2001; AND TO PROVIDE FOR VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative findings and purposes.

(a) The General Assembly finds that:

(1) It is essential to the psychological and physical well-being of a woman who is considering an abortion that she receive complete and

EXHIBIT
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4

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BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative findings and purposes.

(a) The General Assembly finds that:

(1) It is essential to the psychological and physical well-being of a woman who is considering an abortion that she receive complete and

receiving an abortion does so only after giving her voluntary and fully informed consent to the abortion procedure;

(2) Protect unborn children from a woman's uninformed decision to have an abortion;

(3) Reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed", as stated in Planned Parenthood v. Casey, 505 U.S. 833, 882 (1992); and

(4) Adopt the construction of the term "medical emergency" accepted by the United States Supreme Court in Planned Parenthood v. Casey, 505 U.S. 833 (1992).

SECTION 2. Arkansas Code Title 20, Chapter 16, is amended to add an additional subchapter to read as follows:

Subchapter 15 — Woman's Right-to-Know Act

20-16-1501. Title.

This subchapter shall be known and may be cited as the "Woman's Right-to-Know Act".

20-16-1502. Definitions.

As used in this subchapter:

(1)(A) "Abortion" means the act of using or prescribing any instrument, medicine, drug, or other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) A use, prescription, or means under this subdivision (1) is not an abortion if the use, prescription, or means is performed with the intent to:

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

(ii) Remove a dead unborn child caused by spontaneous abortion; or

(iii) Remove an ectopic pregnancy;

(2)(A) "Abortion-inducing drug" means a medicine, drug, or any

drugs;

(B) Bleeding;

(C) A blood clot;

(D) Cardiac arrest;

(E) Cervical perforation;

(F) Coma;

(G) Embolism;

(H) Endometritis;

(I) Failure to actually terminate the pregnancy;

(J) Free fluid in the abdomen;

(K) Hemorrhage;

(L) Incomplete abortion, also referred to as "retained tissue";

(M) Infection;

(N) Metabolic disorder;

(O) Undiagnosed ectopic pregnancy;

(P) Placenta previa in subsequent pregnancies;

(Q) Pelvic inflammatory disease;

(R) A psychological or emotional complication such as depression, anxiety, or a sleeping disorder;

(S) Preterm delivery in subsequent pregnancies;

(T) Renal failure;

(U) Respiratory arrest;

(V) Shock;

(W) Uterine perforation; and

(X) Other adverse event;

(5) "Conception" means the fusion of a human spermatozoon with a human ovum;

(6) "Emancipated minor" means a person under eighteen (18) years of age who is or has been married or who has been legally emancipated;

(7) "Facility" means a public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location where medical care is provided to a person;

(8) "First trimester" means the first twelve (12) weeks of

(A) The name of the physician who will perform the abortion;

(B) Medically accurate information that a reasonable patient would consider material to the decision concerning whether or not to undergo the abortion, including:

(i) A description of the proposed abortion method;

(ii) The immediate and long-term medical risks associated with the proposed abortion method, including without limitation the risks of:

(a) Cervical or uterine perforation;

(b) Danger to subsequent pregnancies;

(c) Hemorrhage; and

(d) Infection; and

(iii) Alternatives to the abortion;

(C) The probable gestational age of the unborn child at the time the abortion is to be performed;

(D) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(E) The medical risks associated with carrying the unborn child to term;

(F) Any need for anti-Rh immune globulin therapy if the woman is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy; and

(G) Information on reversing the effects of abortion-inducing drugs;

(2) At least forty-eight (48) hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person informs the woman, orally and in person, that:

(A) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her under § 20-16-1504;

(B) The printed materials and informational DVD under § 20-16-1504 describe the unborn child and list agencies that offer alternatives to abortion;

of this section and counseling related to that information shall include without limitation the following:

(i) That by twenty (20) weeks gestational age, the unborn child possesses all anatomical links in its nervous system, including spinal cord, nerve tracts, thalamus, and cortex, that are necessary in order to feel pain;

(ii) That an unborn child at twenty (20) weeks gestation or more is fully capable of experiencing pain;

(iii) A description of the actual steps in the abortion procedure to be performed or induced and at which steps in the abortion procedure the unborn child is capable of feeling pain;

(iv) That maternal anesthesia typically offers little pain prevention for the unborn child; and

(v) That an anesthetic, analgesic, or both are available so that pain to the fetus is minimized or alleviated;

(6)(A) Before the abortion, the pregnant woman certifies in writing on a checklist form provided or approved by the Department of Health that the information required under § 20-16-1504 has been provided.

(B) A physician who performs an abortion shall report monthly to the department the total number of certifications the physician has received.

(C) The department shall make available to the public annually the number of certifications received under subdivision (b)(6)(B) of this section;

(7)(A) Except in the case of a medical emergency, the physician who is to perform the abortion shall receive and sign a copy of the written certification required under subdivision (b)(6)(A) of this section before performing the abortion.

(B) The physician shall retain a copy of the checklist certification form in the pregnant woman's medical record; and

(8) At least forty-eight (48) hours before an abortion that is being performed or induced utilizing abortion-inducing drugs, the physician who is to perform the abortion, the referring physician, or a qualified person informs the pregnant woman, orally and in person, that:

(A) It may be possible to reverse the effects of the abortion if the pregnant woman changes her mind, but that time is of the

comprehensible:

(1)(A) Geographically indexed materials that inform a pregnant woman seeking an abortion of public and private agencies and services available to assist her through pregnancy, upon childbirth, and while her child is dependent, including without limitation adoption agencies.

(B) The materials shall:

(i) Include:

(a) A comprehensive list of the public and private agencies and services, a description of the services they offer, and the telephone numbers and addresses of the agencies; and

(b) The following statement: "There are many public and private agencies willing and able to help you to carry your child to term and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of Arkansas strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician or his or her agent give you the opportunity to call agencies like these before you undergo an abortion.";

(ii) Inform the pregnant woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care;

(iii) Contain a toll-free, twenty-four-hour telephone number that may be called to obtain information about the agencies in the geographic area of the caller and of the services offered; and

(iv) State that:

(a) It is unlawful for any individual to coerce a woman to undergo an abortion;

(b) If a minor is denied financial support by the minor's parents, guardian, or custodian due to the minor's refusal to undergo an abortion, the minor shall be deemed emancipated for the purposes of eligibility for public assistance benefits, except that benefits may not be used to obtain an abortion;

(c) A physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action; and

(d) The law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care.

(D) Infection;

(E) Medical risks associated with carrying a child to term following an abortion; and

(F) Possible adverse psychological effects associated with an abortion;

(5) A uniform resource locator for the state website where the materials required under this section can be found;

(6) Materials that include information on the potential ability of a qualified person to reverse the effects of abortion-inducing drugs, such as mifepristone, Mifeprex, and misoprostol, including without limitation information directing a woman to obtain further information at appropriate websites and by contacting appropriate agencies for assistance in locating a healthcare professional to aide in the reversal of an abortion; and

(7) A checklist certification form to be used by the physician or a qualified person assisting the physician that lists the items of information to be given to the woman by a physician or the agent under this subchapter.

(c) The materials shall be printed in a typeface large enough to be clearly legible.

(d)(1) The department shall produce a standard format DVD that may be used statewide presenting the information required under this section.

(2) In preparing the DVD, the department may summarize and make reference to the comprehensive printed list of geographically indexed names and services described in this section.

(3)(A) The DVD shall show, in addition to the information described in this section, an ultrasound of the heartbeat of an unborn child at four to five (4-5) weeks gestational age, at six to eight (6-8) weeks gestational age, and each month thereafter, until viability.

(B) The information in the DVD shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

(e) The materials and the DVD required under this section shall be available at no cost from the department upon request and in appropriate number to any person, facility, or hospital.

20-16-1505. Prevention of forced abortion — Signage in abortion

(a) The Department of Health shall develop and promulgate regulations regarding reporting requirements.

(b)(1) The Arkansas Center for Health Statistics of the Department of Health shall ensure that all information collected by the center regarding abortions performed in this state shall be available to the public in printed form and on a twenty-four-hour basis on the center's website.

(2) In no case shall the privacy of a patient or doctor be compromised.

(c) The information collected by the center regarding abortions performed in this state shall be continually updated.

(d)(1)(A) By June 3 of each year, the department shall issue a public report providing statistics on the number of women who were provided information and materials pursuant to this subchapter during the previous calendar year.

(B) Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information received after the deadline.

(2) The department shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual who received information or materials in accordance with § 20-16-1503.

20-16-1508. Rules.

(a)(1) The Department of Health shall adopt rules to implement this subchapter.

(2) The department may add by rule additional examples of complications to supplement those in § 20-16-1503.

(c) The Arkansas State Medical Board shall promulgate rules to ensure that physicians who perform abortions, referring physicians, or agents of either physician comply with all the requirements of this subchapter.

20-16-1509. Criminal penalty.

A person who intentionally, knowingly, or recklessly violates this subchapter commits a Class A misdemeanor.

20-16-1510. Civil penalties.

~~As used in this subchapter:~~

~~(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant, for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after a live birth, or to remove a dead fetus;~~

~~(2) "Attempt to perform an abortion" means an act or an omission of a statutorily required act that under the circumstances as the actor believes them to be constitutes a substantial step in a course of conduct planned to culminate in the termination of a pregnancy in Arkansas;~~

~~(3) "Board" means the Arkansas State Medical Board or the appropriate health care professional licensing board;~~

~~(4) "Division" means the Department of Health;~~

~~(5) "Director" means the Director of the Department of Health;~~

~~(6) "Gestational age" means the age of the fetus as calculated from the first day of the last menstrual period of the pregnant woman;~~

~~(7) "Medical emergency" means any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of impairment of a major bodily function which is substantial and deemed to be irreversible;~~

~~(8) "Physician" means any person licensed to practice medicine in this state; and~~

~~(9) "Probable gestational age of the fetus" means what in the judgment of the physician will with reasonable probability be the gestational age of the fetus at the time the abortion is planned to be performed.~~

~~20-16-903. Informed consent.~~

~~(a) No abortion shall be performed in this state except with the voluntary and informed consent of the woman upon whom the abortion is to be performed.~~

~~(b) Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:~~

~~(1)(A) Before and in no event on the same day as the abortion, the woman is told the following by telephone or in person by the physician~~

~~available for prenatal care, childbirth, and neonatal care;~~

~~(ii) That the father is liable to assist in the support of her child, even in instances in which the father has offered to pay for the abortion;~~

~~(iii) That she has the option to review the printed or electronic materials described in § 20-16-904 and that those materials:~~

~~(a) Have been provided by the state; and~~

~~(b) Describe the fetus and list agencies that offer alternatives to abortion; and~~

~~(iv) That if the woman chooses to exercise her option to view the materials:~~

~~(a) In a printed form, the materials shall be mailed to her by a method chosen by her; or~~

~~(b) Via the Internet, she shall be informed before and in no event on the same day as the abortion of the specific address of the website where the materials can be accessed.~~

~~(B) The information required by this subdivision (b)(2) may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to review the printed materials;~~

~~(3) Before the abortion, the woman certifies in writing that the information described in subdivision (b)(1) of this section and her options described in subdivision (b)(2) of this section have been furnished to her and that she has been informed of her option to review the information referred to in subdivision (b)(2)(A)(iii) of this section;~~

~~(4) Before the abortion, the physician who is to perform the procedure or the physician's agent receives a copy of the written certification prescribed by subdivision (b)(3) of this section; and~~

~~(5) Before the abortion, the physician confirms with the patient that she has received information regarding:~~

~~(A) The medical risks associated with the particular abortion procedure to be employed;~~

~~(B) The probable gestational age of the fetus at the time the abortion is to be performed;~~

~~(C) The medical risks associated with carrying the fetus to term; and~~

~~designed to convey only accurate scientific information about the fetus at the various gestational ages.~~

~~(C) The material shall also contain objective information describing:~~

~~(i) The methods of termination of pregnancy procedures commonly employed;~~

~~(ii) The medical risks commonly associated with each of those procedures;~~

~~(iii) The possible detrimental psychological effects of termination of pregnancy; and~~

~~(iv) The medical risks commonly associated with carrying a child to term.~~

~~(b) The materials referred to in subsection (a) of this section shall be printed in a typeface large enough to be clearly legible.~~

~~(c) The materials required under this section shall be available at no cost from the department and shall be distributed upon request in appropriate numbers to any person, facility, or hospital.~~

~~(d)(1) The department shall develop and maintain a secure website to provide the information described under subsection (a) of this section.~~

~~(2) The website shall be maintained at a minimum resolution of seventy-two pixels per inch (72 ppi).~~

~~20-16-905. Procedure in case of medical emergency.~~

~~When a medical emergency compels the performance of an abortion, the physician shall inform the woman, prior to the abortion if possible, of the medical indications supporting the physician's judgment that:~~

~~(1) An abortion is necessary to avert her death; or~~

~~(2) A delay will create a serious risk of impairment of a major bodily function which is substantial and deemed to be irreversible.~~

~~20-16-906. Regulations — Collection and reporting of information.~~

~~(a) The Department of Health shall develop and promulgate regulations regarding reporting requirements.~~

~~(b) The Arkansas Center for Health Statistics of the Department of Health shall ensure that all information collected by the center regarding abortions performed in this state shall be available to the public in printed~~

~~exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure.~~

~~(c) Each order to preserve the woman's anonymity shall be accompanied by specific written findings explaining:~~

~~(1) Why the anonymity of the woman should be preserved from public disclosure;~~

~~(2) Why the order is essential to that end;~~

~~(3) How the order is narrowly tailored to serve that interest; and~~

~~(4) Why no reasonable less restrictive alternative exists.~~

~~(d) This section shall not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.~~

SECTION 4. DO NOT CODIFY. The enactment and adoption of this act shall be in conjunction with and not supersede the Arkansas Human Heartbeat *Protection Act, § 20-16-1301 et seq., derived from Acts 2013, No. 301.*

SECTION 5. DO NOT CODIFY. SAVINGS CLAUSE. If any section or part of a section of this act is determined by a court to be unconstitutional, the Woman's Right to Know Act of 2001, § 20-16-901 et seq., shall be revived, and to prevent a hiatus in the law, the relevant section or part of a section of the Woman's Right to Know Act of 2001 shall remain in full force and effect from and after the effective date of this act notwithstanding its repeal by this act.

/s/Lundstrum

APPROVED: 04/06/2015

BEFORE THE ARKANSAS BOARD OF HEALTH

ADH Brief in Support of Deficiency Findings
and Response to Motion to Dismiss

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH	PETITIONER
v.	
LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA d/b/a PLANNED PARENTHOOD GREAT PLAINS	RESPONDENTS

BACKGROUND

The facts giving rise to this matter are not in dispute. In 2015, "The Woman's Right to Know Act" ("the Act") was passed.[1,2] In pertinent part, the Act required certain information to be provided to a woman at least 48 hours before aborting a fetus ("reflection period"). The Act also prohibited a **physician** from requiring or obtaining payment for abortion-related services until after the 48-hour reflection period ("payment delay").[3] On or about August 5, 2016, petitioner Arkansas Department of Health ("ADH") issued a deficiency citation to respondent Little Rock Family Planning Services (LRFPS) for violating the payment delay by failing to prohibit collecting such fees. However, upon LRFPS' objection, ADH retracted the citation agreeing that ADH and the Board of Health lacked authority over physician billing and that no Board of Health rule covered the offending conduct.[4]

In 2017, the Act was amended to include facilities, employees, volunteers, or any other person or entity[5] (along with physicians) as those bound by the payment delay.

In March 2018,[6,7] ADH investigated a complaint that the three respondent facilities were noncompliant with the payment delay. ADH found the complaint to be substantiated and cited the respondents for deficiencies under A.C.A. 20-16-1703(d)[8]. (Petitioner Exhibit 1) From the citations, Respondents appeal.

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[1] Act 1086 of 2015, codified at A.C.A. 20-16-1701 through 17011, attached as Exhibit 4 to Respondents Brief.
[2] Repealing a 2001 Act by the same name
[3] A.C.A. 20-16-1703(d)
[4] See Respondent's Exhibit B to Exhibit 1
[5] Act 383 of 2017
[6] March 13 to Little Rock Family Planning Services
[7] March 23 to Planned Parenthood Fayetteville and Planned Parenthood Little Rock
[8] *A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight- hour reflection period required in this section.*

ADH and Respondents have agreed to submit the matter to this Board for determination on written briefs. In order to preserve certain constitutional questions for future appeal, the issues are necessarily included in the Brief submitted by Respondents, along with tort claims. Because an administrative agency does not have authority to determine the constitutionality of a statute[9] and there is a presumption of constitutionality of a statute[10], ADH has not included those constitutional arguments in this Brief.

ISSUES BEFORE THE ARKANSAS BOARD OF HEALTH

1. ADH is authorized to investigate the subject matter of the complaint and did not exceed its authority.

a. Licensing and regulatory authority – A.C.A. 20-9-302

ADH is authorized and required by A.C.A. 20-9-302 ("licensing authority statute") to license and inspect abortion facilities, among other things. Petitioner Exhibit 2

Sections (a) and (b) read as follows:

> *(a) (1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted in any month, including nonsurgical abortions,* ***shall be licensed by the Department of Health.***
>
> *(2) (A)* ***The department shall inspect*** *a clinic, health center, or other facility at least annually, and inspections shall include without limitation:*
>
> *(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and*
>
> *(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.*
>
> *(B) An* ***inspector shall arrive at the clinic****, health center, or other facility unannounced and without prior notice.*
>
> *(b) The department shall:*

[9] *Teston v. Arkansas State Board of Chiropractic Examiners*, 361 Ark. 300 (2005).
[10] *Bayer CropScience LP v. Shafer*, 2011 Ark. 518

> *(1) Adopt appropriate rules, including without limitation the facilities, equipment,* ***procedures****, techniques, medical records,* ***informed consent signatures****, parental consent signatures, and conditions of clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:*
>
> > *(A) The facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard; and*
> >
> > *(B) The medical records,* ***informed consent signatures****, and parental consent signatures* ***meet statutory requirements****;* (emphasis added)

Thus, ADH is to license, inspect, and adopt appropriate rules[11] to assure that health standards and statutory requirements are met. The statutory language is clear and unequivocal that ADH has both the authority and responsibility to inspect Respondents licensed facilities and to assure that the facilities meet statutory requirements (including informed consent signatures).

ADH has adopted and continues the promulgation of appropriate rules pursuant to the licensing authority statute. A copy of the *Rules and Regulations for Abortion Facilities in Arkansas* ("Rules") is attached hereto as Petitioner's Exhibit 3.

b. Payment delay is a component of "informed consent"

When the payment delay was extended in 2017 to apply to facilities, the amending language made clear that such payment delay is part of the informed consent requirements which must precede an abortion in Arkansas. Section 3 of Act 383 of 2017 states in its entirety:

> *SECTION 3. Arkansas Code § 20-16-1703(d),* ***concerning the informed consent requirement*** *within the Woman's Right-to-Know Act, is amended to read as follows:*
>
> > *(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section.* (bold emphasis added)

[11] ADH administers rules adopted by the Arkansas State Board of Health

c. Licensing authority statute directs ADH to enforce informed consent signature requirements – no additional rule is required

As discussed in paragraph (a), the licensing authority statute directs ADH to inspect abortion facilities and to assure that the facilities meet statutory requirements (including informed consent signatures). Payment delay is part of an overall 48-hour reflection period through which valid informed consent is obtained. The reflection period allows for due consideration of the abortion based on information provided at the time of inquiry. As such, signatures obtained for payment delay purposes are among the informed consent signatures that ADH is statutorily directed to review, with an end to assure statutory requirements are met. No additional rule is necessary for ADH to accomplish this express duty.

d. Informed consent requirement statute makes the 48-hour reflection period applicable to Respondent's facilities – a rule unnecessary

When enacted in 2015, payment delay language specified that "a physician" shall not require or obtain payment until after the reflection period. In 2017, the payment delay (A.C.A. 20-16-1703(d)) was amended[12] to also expressly include "facilities, employees, volunteers, or any other person or entity." A copy of the amending act (Act 383 of 2017) is attached as Petitioner's Exhibit 3 showing the change in strike-through format. Arkansas has long required a liberal construction of such remedial legislation. *Chicago Mill & Lumber Co. v. Smith*, 228 Ark. 876 (1958). By its plain language, the payment delay applies to facilities under regulatory authority of ADH.

e. Where a rule is unnecessary, its absence is wholly appropriate

A.C.A. 20-16-1703(d) is clear that a facility *shall not require or obtain payment* until the 48-hour reflection period has passed. A rule is unnecessary to give effect to such plain and unequivocal language. The absence of an ADH rule is therefore appropriate under the licensing authority statute, A.C.A. 20-9-302(b)(1), which specifies that ADH is to adopt *appropriate* rules.

f. Informed consent requirement statute makes all signed forms available to ADH – no additional rule is required

A.C.A. 20-16-1703(e) declares that "all ultra sound images, test results, and **forms signed by the patient** or legal guardian shall be retained as a part of the patient's medical record and be made available for inspection by the department or other authorized agency." The basic rule of statutory construction is to give effect to the legislative intent and when the language is plain and unambiguous the statue is construed by giving ordinary and usually accepted meaning in common language. *See Ozark Gas Pipeline Corp. v. Ark. Public Service Commission,* 342 Ark. 591 (2000). The plain language of the statue requires that any document(s) signed with respect to payment agreements during the payment delay must be kept and made available to ADH.

[12] Section 3, page 4, L. 36; page 5

2. **ADH was not acting in an arbitrary or capricious manner by issuing a deficiency citation based on the 2017 change in the law.**

As previously outlined in this Petition, ADH had withdrawn a deficiency finding in 2016 based on the law that was in place at that time in which the restriction against requiring or obtaining payment until after a 48-hour reflection period was applicable only to "a physician". However, in 2017 law was amended. The amendment expanded application to include a "facility, employee or volunteer of a facility or any other person or entity." The legislative remediation easily distinguishes the current citation(s) from the one withdrawn in 2016. ADH citations, findings, letters, and transactions in 2016 under prior law are inapplicable to the current citations under the amended law.

3. **ADH was not acting in an arbitrary and capricious manner by issuing a deficiency citation for the collection of credit card information with the 48 hour period.**

A mere delay is not a taking, particularly where the delay is imposed for valid public policy reasons. One such example is healthcare services provided to employees injured on the job. Providers are restricted from billing injured employees who suffer work-related injuries once the provider has notice. A.C.A.11-9-118.

In *Arkansas State Police Comm'n v. Smith*, 338 Ark. 354 (1999)3, the court ruled that an administrative action may not be regarded as arbitrary and capricious unless it is not supportable on any rational basis. In order to have any action set aside as arbitrary and capricious, the challenging party must show that the action was willful and unreasoning, without consideration, and with a disregard of the facts or circumstances. *Id.* Respondents have presented no valid argument that ADH's conduct rose to this standard.

4. **By following state law, there has been no action constituting tortious interference with contract.**

ADH has not acted in an arbitrary and capricious manner in following the state statute. Moreover, sovereign immunity precludes a claim for tortious interference with contract and the Respondents have failed to assert a fact that would preclude applying the doctrine of sovereign immunity. *See Milligan v. Burrow*, 52 Ark. App. 20, (1996)

Conclusion

The Petitioner respectfully requests that the Arkansas Board of Health uphold the deficiency citations that were issued.

Respectfully submitted,

Ann Purvis, J.D.
Arkansas Bar License 88153
Deputy Director for Administration
4815 West Markham
Little Rock, AR 72205
501-280-4545

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

March 13, 2018

[redacted]
Planned Parenthood of Arkansas and Eastern Oklahoma
3729 North Crossover, Suite 107
Fayetteville, AR 72703

Re: Complaint Investigation 02/01/18

Dear [redacted]

On February 1, 2018, the Arkansas Department of Health conducted a complaint investigation at your facility. Based on document review and confirmation by interviews, it was determined the facility has possibly been requiring or obtaining payment for services provided in relation to abortion before the expiration of the forty-eight-hour reflection period, in violation of Ark. Code Ann. § 20-16-1703(d). To further assist our investigation, we ask that you provide the following information:

- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by credit or debit card.
- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by cash.
- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by any means other than credit card, debit card, or cash.

Pursuant to Arkansas Ann Code §20-9-302 (3)(A)(ii) you have thirty (30) days from the mailing of this notice to submit your plan for correction of the violation or ask for a hearing. If you fail to do so, the license will be suspended. The suspension shall remain in effect until all violations have been corrected pursuant to §20-9-302 (3)(A)(iv).

Sincerely,

Becky Bennett

Becky Bennett, Section Chief
Health Facility Services
Phone: 501-661-2201

Petitioner Exhibit 1

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

March 13, 2018

[redacted]
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

Re: Complaint Investigation 01/30/18

Dear [redacted],

On January 30, 2018, the Arkansas Department of Health conducted a complaint investigation at your facility. Based on document review and confirmation by interviews, it was determined your facility has been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight-hour reflection period, in violation of Ark. Code Ann. § 20-16-1703(d).

Pursuant to Arkansas Ann Code §20-9-302 (3)(A)(ii) you have thirty (30) days from the mailing of this notice to submit your plan for correction or ask for a hearing. If you fail to do so, the license will be suspended. The suspension shall remain in effect until all violations have been corrected pursuant to §20-9-302 (3) (A)(iv).

Sincerely,

Becky Bennett

Becky Bennett, Section Chief
Health Facility Services
Phone: 501-661-2201

20-9-302. Abortion clinics, health centers, etc.

(a)

(1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted in any month, including nonsurgical abortions, shall be licensed by the Department of Health.

(2) (A) The department shall inspect a clinic, health center, or other facility at least annually, and inspections shall include without limitation:

(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and

(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.

(B) An inspector shall arrive at the clinic, health center, or other facility unannounced and without prior notice.

(b) The department shall:

(1) Adopt appropriate rules, including without limitation the facilities, equipment, procedures, techniques, medical records, informed consent signatures, parental consent signatures, and conditions of clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:

(A) The facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard; and

(B) The medical records, informed consent signatures, and parental consent signatures meet statutory requirements;

(2) Levy and collect an annual fee of five hundred dollars ($500) per facility for issuance of a permanent license to an abortion facility; and

(3) (A) Deny, suspend, or revoke licenses on any of the following grounds:

(i) The violation of any provision of law or rule; or

(ii) The permitting, aiding, or abetting of the commission of any unlawful act in connection with the operation of the institutions.

(B)

(i) If the department determines to deny, suspend, or revoke a license, the department shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(ii) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(iii) ***(a)*** The department shall issue an immediate suspension of a license if an investigation or survey determines that:

(1) The applicant or licensee is in violation of any state law, rule, or regulation; and

Petitioner Exhibit 2

(2) The violation or violations pose an imminent threat to the health, welfare, or safety of a patient.

(b)

(1) The department shall give the applicant or licensee written notice of the immediate suspension.

(2) The suspension of the license is effective upon the receipt of the written notice.

(iv) The denial, suspension, or revocation order shall remain in effect until all violations have been corrected.

(C) The applicant or licensee shall:

(i) Be given a fair hearing; and

(ii) Have the right to present evidence as may be proper.

(D)

(i) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(ii) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

(iii) The decision shall become final fifteen (15) days after it is mailed unless the applicant or licensee, within the fifteen-day period, appeals the decision to the court.

(E) A full and complete record of all proceedings shall be kept and all testimony shall be reported, but it need not be transcribed unless the decision is appealed or a transcript is requested by an interested party who shall pay the cost of preparing the transcript.

(F) Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by rule.

(G) The procedure governing hearings authorized by this section shall be in accordance with rules promulgated by the department.

(c)

(1) Applicants for a license shall file applications upon such forms as are prescribed by the department.

(2) A license shall be issued only for the premises and persons in the application and shall not be transferable.

(d)

(1) A license shall be effective on a calendar-year basis and shall expire on December 31 of each calendar year.

(2) Applications for annual license renewal shall be postmarked no later than January 2 of the succeeding calendar year.

(3) License applications for existing institutions received after that date shall be subject to a penalty of two dollars ($2.00) per day for each day after January 2.

(e) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the abortion clinics that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

(f) All fees levied and collected under this section are special revenues and shall be deposited into the State Treasury to be credited to the Public Health Fund.

Agency # 007.05

RULES AND REGULATIONS FOR ABORTION FACILITIES IN ARKANSAS

ARKANSAS DEPARTMENT OF HEALTH
2017

Petitioner Exhibit 3

Rules and Regulations For Abortion Facilities 2014

Rules and Regulations For Abortion Facilities 2014

SECTION 1. PREFACE.

These Rules and Regulations have been prepared for the purpose of establishing criteria for minimum standards for licensure, operation and maintenance of Abortion Facilities. By necessity they are of a regulatory nature but are considered to be practical minimum design and operational standards for their facility type. These standards are not static and are subject to periodic revisions. It is expected Abortion Facilities will exceed these minimum requirements and will not be dependent upon future revisions as a necessary prerequisite for improved services.

Rules and Regulations For Abortion Facilities 2014

SECTION 2. AUTHORITY.

These Rules and Regulations for Abortion Facilities in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Acts 509 of 1983 and 1176 of 2011; Ark. Code Ann. § 20-9-302 as amended.

Rules and Regulations For Abortion Facilities 2017

SECTION 3. DEFINITIONS.

Note: see Section 12 for additional definitions for Physical Facilities requirements

A. **Abortion** - the use or prescription of any instrument, medicine, drug, or any other substance or device:

1. To terminate the pregnancy of a woman known to be pregnant with an intention other than to:
   a. Increase the probability of a live birth;
   b. Preserve the life or health of the child after live birth; or
   c. to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and

2. Which causes the premature termination of the pregnancy.

Note: Abortions are prohibited during and after the twentieth (20th) week of a woman's pregnancy except as authorized by law. See Ark. Code Ann. § 20-16-1401 et seq.

B. **Abortion Facility** - A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted each month, including non-surgical abortions.

C. **Act** - Act 509 of 1983 as amended by Act 1176 of 2011.

D. **Administrator** - an individual designated to provide daily supervision and administration of the Abortion Facility.

E. **Consent** - a signed and witnessed voluntary agreement for the performance of an abortion.

F. **Dead fetus or fetal remains** - a product of human conception exclusive of the placenta or connective tissue, which has suffered death prior to the complete expulsion or extraction from the mother as established by the fact that, after the expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

G. **Department** - the Arkansas Department of Health.

H. **Division** - the Division of Health Facility Services.

I. **Director** - the Chief Administrative Officer in the Division of Health Facility Services.

J. **General Abortion Facility** - an abortion facility that provides surgical abortions or both medical and surgical abortions.

K. **Hospital** - Any acute care facility established for the purpose of providing inpatient diagnostic care and treatment.

L. **Local Anesthesia** – Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug.

M. **Medical abortion** - a non-surgical abortion for which abortifacient pharmaceutical drugs are used to induce the abortion.

N. **Medical-Only Abortion Facility** - an abortion facility in which no surgical abortions are performed.

O. **Minimal Sedation (Anoxiolysis)** – a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected.

P. **Moderate Sedation/Analgesia ("Conscious Sedation")** – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate.

Q. **Patient** - any woman receiving services in the facility.

R. **Surgical abortion** means a pregnancy is ended by surgically removing the contents of the uterus through use of suction device or other instrument(s).

Rules and Regulations For Abortion Facilities 2017

SECTION 4. LICENSING.

A. Application for License. Application for a license or renewal of a license shall be made on forms provided by the Arkansas Department of Health. The application shall set forth:

1. The complete name and address of the Abortion Facility

2. The facility type:

(a) General Abortion Facility; or

(b) Medical-Only Abortion Facility; and

3. Additional information as required by the Arkansas Department of Health.

B. Grandfather provisions.

1. A facility, in existence on January 1, 2012 and in substantial compliance with the physical facility requirements in Section 12, submitting initial application for licensure by July 1, 2012 is exempted from the physical facility requirements in Section 12 of these Rules for its existing physical structure. Notwithstanding this provision, a facility must be in compliance with these rules after January 1, 2014, unless the modifications would be impracticable.

2. Except as otherwise provided in Section (4)(B)(1), Abortion Facilities shall comply with all requirements set forth in these Rules and Regulations. The Rules and Regulations shall become effective on January 1, 2012.

C. Availability of Emergency Services. A General Abortion Facility shall be within thirty (30) minutes of a hospital which provides gynecological or surgical services.

D. Fee. Each application for initial licensure of an Abortion Facility shall be accompanied by a fee of five hundred dollars ($500). The fee shall be payable to the Arkansas Department of Health.

E. Renewal of License. A license, unless revoked, shall be renewable annually upon payment of a fee of five hundred dollars ($500) to the Arkansas Department of Health accompanied by an application for re-licensure. The application for annual license renewal along with the fee shall be postmarked no later than January 2 of the year for which the license is issued.

F. Issuance of License. A license shall be issued only for the premises, services, and person or persons reflected in the application. The license shall be posted in a conspicuous place in the Abortion Facility. The license shall be effective on a calendar year basis and shall expire on December 31 of each calendar year. The license shall not be transferrable and shall expire if a change of ownership occurs.

G. Change of Ownership. It shall be the responsibility of the Abortion Facility to notify the

Division of Health Facility Services in writing at least thirty (30) days prior to the effective date of a change of ownership. The following information shall be submitted for review and approval:

1. license application;

2. five hundred dollars ($500) change of ownership fee; and

3. legal documents, ownership agreements, and other information to support re-licensure requirements.

H. Management Contract. It shall be the responsibility of the Abortion Facility to notify the Division of Health Facility Services in writing at least thirty (30) days prior to entering into a management contract or agreement with an organization or firm. A copy of the contract or agreement shall be submitted for review to assure the arrangement does not affect the license status.

I. Closure. Once an Abortion Facility closes, it shall no longer be considered licensed. The license issued to the Abortion Facility shall be returned to the Division of Health Facility Services. To be eligible for re-licensure, the Abortion Facility shall meet requirements for new construction and all the current life safety and health regulations.

J. Inspection. Any authorized representative of the Arkansas Department of Health shall have the right to enter upon or into the premises of any Abortion Facility at any time in order to make whatever inspection it deems necessary in order to assure minimum standards and regulations are met.

SECTION 5. GOVERNING BODY.

An Abortion Facility shall have an organized Governing Body, consisting of at least one (1) member, which may be the Medical Director, with local representation which shall be legally responsible for maintaining patient care and establishing policies for the facility and shall be legally responsible for the conduct of the facility.

A. The Governing Body Bylaws. The Governing Body shall adopt written bylaws which shall ensure the following:

1. Maintenance of professional standards of practice;

2. Terms, responsibilities and methods of selecting members and officers;

3. Methods by which Quality Improvement is established; and

4. Compliance with federal, state and local laws.

B. Governing Body Minutes. The Governing Body minutes shall include at least the following information:

1. Review, approval and revision of the Governing Body bylaws, rules, regulations and protocols;

2. Review and approval of the Quality Improvement Plan for the facility at least annually, and review of Quality Improvement summaries at least quarterly.

C. Quality Improvement (QI) Program.

1. The Abortion Facility shall develop, implement, and maintain a QI program to include:

(a) Collection of data on the functional activities identified as priorities in QI and benchmark against past performance and national or local standards; and

(b) Development and implementation of improvement plans for identified issues, with monitoring, evaluation and documentation of effectiveness.

2. The scope of the QI Program shall include, but not be limited to, activities regarding the following:

(a) Assessment of processes and outcomes utilizing facility-specific clinical data;

(b) Evaluation of patient satisfaction;

(c) Evaluation of staff performance according to facility protocols; and

(d) Complaint resolution.

3. The facility shall evaluate the effectiveness of the QI Program annually and establish priorities for the QI Program.

SECTION 6. GENERAL ADMINISTRATION.

A. Each facility shall have an Administrator responsible for the management of the facility. The Medical Director may also function as facility administrator.

B. Policies and procedures shall be provided for the general administration of the facility and for each service. All policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date and signatures of the person(s) conducting the review.

C. Provisions shall be made for safe storage of patients' valuables.

D. Each facility shall develop and maintain a written disaster plan which includes provisions for complete evacuation of the facility. The plan shall provide for widespread disasters as well as for a disaster occurring within the local community or the facility. The disaster plan shall be rehearsed at least twice a year. One (1) drill shall simulate a disaster of internal nature and the other external. Written reports and evaluation of all drills shall be maintained.

E. There shall be posted a list of names, telephone numbers, and addresses available for emergency use. The list shall include the key facility personnel and staff, the local police department, the fire department, ambulance service, Red Cross, and other available emergency units. The list shall be reviewed and updated at least every six (6) months.

F. There shall be current reference material available onsite to meet the professional and technical needs of Abortion Facility personnel including current books, periodicals, and other pertinent materials.

G. All employees shall be required to have annual in-services on safety, fire safety, back safety, infection control, universal precautions, disaster preparedness and confidential information.

H. Procedures shall be developed for the retention and accessibility of the patients' medical records if the Abortion Facility closes.

I. Any Abortion Facility that closes shall meet the requirements for new construction in order to be eligible for re-licensure. Once a facility closes, it is no longer licensed. The license shall be immediately returned to Health Facility Services. To be eligible for licensure, all the referenced National Fire Codes (NFPA) and health regulations shall be met.

J. Written consent for the performance of an induced abortion must be obtained and signed by the patient prior to the abortion and after counseling by a qualified professional. Written or verbal consent shall not release the facility or its personnel from upholding the rights of patients including, but not limited to, the right to privacy, dignity, security, confidentiality, and freedom from abuse or neglect.

K. Each facility shall have a Medical Director who shall be a physician currently licensed to practice medicine in Arkansas, and who shall be responsible for the direct coordination of all medical aspects of the facility program.

L. There shall be written policies and procedures developed and approved by the Medical Director and Administrator which define the care provided at the facility.

M. Policies and procedures shall include, but not be limited to the following:

1. personnel policies;
2. provision of medical and clinical services;
3. provision of laboratory services;
4. examination of fetal tissue;
5. disposition of medical waste;
6. emergency services;
7. criteria for discharge;
8. health information systems (including electronic records);
9. provision of pharmacy services;
10. medication administration;
11. anesthesia/analgesia/sedation administration as applicable;
12. counseling services;
13. patient education;
14. infection control, including post- abortion surveillance;
15. fire, safety, and disaster preparedness;
16. housekeeping;
17. laundry;
18. preventive maintenance;
19. processing and/or storage of sterile supplies;
20. patient care;
21. probable post-fertilization age determination; and
22. proper disposition of dead fetuses and fetal remains.

N. Administrative Reports. The Administrator or his/her designee shall report: infectious or communicable diseases to the Arkansas Department of Health, as required by:

1. the Rules and Regulations Pertaining to Communicable Disease in Arkansas (Ark. Code Ann. §§ 20-7-109, 110.); and

2. the Rules Pertaining to the Control of Communicable Diseases-Tuberculosis.

O. Each facility shall ensure that each dead fetus or fetal remains are disposed of in accordance with the provisions of Ark. Code Ann. § 20-17-102.

1. The requirements of this subsection shall not apply to abortions induced by the administration of medications when the evacuation of any human remains occurs at a later time and not in the presence of the inducing physician nor at the facility in which the physician administered the inducing medications.

SECTION 7. PATIENT CARE SERVICES.

An Abortion Facility shall have an adequate number of personnel qualified under this section available to provide direct patient care as needed.

A. Qualifications.

1. Only physicians who are currently licensed to practice medicine in Arkansas may perform abortions.

2. All facility personnel, medical and others, shall be licensed to perform the services they render when such services require licensure under the laws of the State of Arkansas. Documentation of current licensure shall be maintained in the personnel file for each employee.

3. Providers of patient counseling shall, at a minimum, possess current licensure as a nurse, Social Worker, or documented experience and training in a related field. Special training in counseling which is deemed acceptable by the Department shall be required.

4. All clinical staff of the facility shall be required to provide documentation of training and continued competence in cardiopulmonary resuscitation (CPR) or its equivalent.

B. Staffing Requirements.

1. There shall be a sufficient number of Registered Nurses in the facility at all times when patients are present.

2. Registered Nurses shall be on duty to supply or supervise all nursing care of patients.

C. Authority and responsibilities of all patient care staff shall be clearly defined in written policies, including periodic monitoring and assessment of patients.

D. Services shall be organized to ensure management functions are effectively conducted. These functions shall include, but are not limited to:

1. review of policies and procedures at least annually to reflect current standards of care;

2. establishment of a mechanism for review and evaluation of care and services provided at the facility;

3. orientation and maintenance of qualified staff for provision of patient care;

4. annual in-service education programs for professional staff; and

5. provision of current nursing literature and reference materials.

E. Patients shall have access to twenty-four (24) hour telephone consultation with either a

Registered Nurse or physician associated with the facility.

F. A Registered Nurse shall plan, supervise, and evaluate the nursing care of each patient from admission to the facility through discharge.

G. Counseling services shall be provided for each patient, as follows:

1. prior to the abortion, the patient shall be counseled regarding the abortion procedure, alternatives to abortion, informed consent, medical risks associated with the procedure, potential post-abortion complications, community resources and family planning;

2. documentation of counseling shall be included in the patient's medical record;

3. if counseling is performed in groups, the patient shall be offered an opportunity to meet privately with a qualified counselor;

4. each patient shall be assessed by a Registered Nurse for counseling needs post-abortion;

5. written instructions for post-abortion care shall be given to the patient at discharge, to include at least the following:

   (a) signs and symptoms of possible complications;

   (b) activities allowed and to be avoided;

   (c) hygienic and other post-discharge procedures to be followed;

   (d) abortion Facility emergency telephone numbers available on a twenty-four (24) hour basis; and

   (e) follow up appointment, if indicated.

6. The patient shall be counseled regarding Rh typing and shall be given Rh immune globulin, if indicated.

Rules and Regulations For Abortion Facilities 2017

SECTION 8. PROGRAM REQUIREMENTS.

A. Admission Evaluation. Every woman seeking to have an abortion shall be registered by the facility and evaluated by means of a history, physical examination, counseling, and laboratory tests.

1. Verification of Pregnancy. Pregnancy testing shall be available to the patient and may precede actual registration by the facility. No abortion shall be performed unless the examining physician verifies the patient is pregnant. Pregnancy test results shall be filed in the patient's medical record.

2. History and Physical Examination. Prior to the abortion, a medical history shall be obtained and recorded. The patient shall be given an appropriate physical examination, as determined by the physician, which may include testing for sexually transmitted diseases. The facility shall report positive test results for sexually transmitted diseases to the Department of Health, as required. Pelvic examinations shall be performed only by qualified personnel, as defined by their Practice Acts.

3. Pre- abortion Tests. The following are required prior to an abortion: hematocrit or hemoglobin, Rh typing, and onsite proof of pregnancy, such as pregnancy test, copy of a pregnancy test or ultrasound. Other testing may be performed according to facility policy.

4. Counseling. Patient counseling services shall be offered prior to initiation of any abortion and if indicated following the abortion. In addition to verbal counseling, patients shall be given and allowed to keep printed materials.

B. Transfer. The Abortion Facility shall have written procedures for emergency transfer of a patient to an acute care facility.

C. Anesthetic agents.

1. Anesthesia, analgesia and anoxiolysis shall be administered only by a qualified professional acting within the scope of his or her Arkansas license.

2. Anesthesia administration in Abortion Facilities shall be limited to local anesthesia, minimal sedation, and moderate sedation.

D. Discharge criteria, developed by the clinical staff and approved by the Governing Body, may be utilized to evaluate patients' medical stability for discharge. Patients may be discharged only on the order of a physician. Patients receiving sedation shall be discharged in the company of a responsible adult.

E. Complications.

1. General Abortion Facilities shall have emergency drugs, oxygen and intravenous fluids available to stabilize the patient's condition, when necessary. An ambu bag, suction equipment and endotracheal equipment shall be located in the clinical area for immediate access.

2. Medical-Only Abortion Facilities shall have oxygen, medication, oral airways and supplies available.

3. All clinical staff shall have documented current competency in cardiopulmonary resuscitation (CPR).

F. Report of Induced Termination. In accordance with Act 120 of 1981, each induced termination of pregnancy which occurs in Arkansas shall be reported to the Division of Health Statistics on a monthly basis by the person in charge of the Abortion Facility.

G. Denial, Suspension or Revocation. The Department may deny, suspend or revoke the license of any Abortion Facility on the following grounds: violation of any of the provisions of the Act or Rules and Regulations lawfully promulgated hereunder; and/or conduct or practices detrimental to the health or safety of patients and employees of any such facilities. This provision shall not be construed to have any reference to healing practices authorized by law.

SECTION 9. HEALTH INFORMATION SERVICES.

The Abortion Facility shall maintain a system for the completion and storage of the medical record. The record shall provide a format for continuity and documentation of legible, uniform, complete, and accurate patient information readily accessible and maintained in a system that ensures confidentiality.

A. General Requirements.

1. The Abortion Facility shall adopt a record form for use that contains information required for transfer to an acute care facility.

2. Record reviews with criteria for identification of problems and follow up shall be reported to the Medical Director at least quarterly.

3. Responsibility for the processing of records is assigned to an individual employed by the Abortion Facility.

4. All medical records shall be retained in either the original, microfilm, or other acceptable methods for ten (10) years after the last discharge.

5. The original or a copy of the original (when the original is not available) of all reports shall be filed in the medical record.

6. The record shall be permanent and shall be either typewritten or legibly written in blue or black ink.

7. All typewritten reports shall include the date of dictation and the date of transcription.

8. All dictated records shall be transcribed within forty-eight (48) hours.

9. Errors shall be corrected by drawing a single line through the incorrect data, labeling it as "error", initialing, and dating the entry.

10. Policies and procedures for Health Information Services shall be developed. The manual shall have evidence of ongoing review and/or revision. The first page of the manual(s) shall have the annual review date and signatures of the person(s) conducting the review.

11. Medical records shall be protected to ensure confidentiality, prevent loss, and ensure reasonable availability.

12. All medical records, whether stored within the facility or away from the facility shall be protected from destruction by fire, water, vermin, dust, etc.

13. Medical records shall be considered confidential. All medical records (including those filed outside the facility) shall be secured at all times. Records shall be available to authorized personnel from the Arkansas Department of Health.

14. Written consent of the patient or legal guardian shall be presented as authority

for release of medical information. There shall be policies and procedures developed concerning all phases of release of information.

15. Original medical records shall not be removed from the facility except upon receipt of a subpoena duces tecum by a court having authority for issuing such an order.

16. Medical records shall be complete and contain all required signed documentation no later than thirty (30) days following the patient's discharge.

17. After the required retention period, medical records may be destroyed by burning or shredding. Medical records shall not be disposed of in landfills or other refuse collection sites.

18. Each entry into the medical record shall be authenticated by the individual who is the source of the information. Entries shall include all observations, notes, and any other information included in the record.

19. Signatures shall be, at least, the first initial, last name, and title. Computerized signatures may be either by code, number, initials, or the method developed by the facility.

20. There shall be policies and procedures for use of electronic medical records. The policies and procedures shall provide for the use, exchange, security, and privacy of electronic health information. The policies and procedures shall provide for standardized and authorized availability of electronic health information for patient care and administrative purposes. The policies and procedures will be in compliance with current guidelines and standards as established in federal and state statutes.

B. Record Content. Each record shall include but not be limited to documentation of:

1. demographic and patient information;

2. informed consent;

3. complete family, medical, social, reproductive, nutrition, and behavioral history;

4. initial physical examination, evaluation of risk status, and laboratory test results;

5. appropriate referral of patients, as indicated;

6. documentation of each periodic examination;

7. patient counseling regarding the abortion, alternatives to abortion, informed consent, medical risks associated with the abortion, potential post-abortion complications, available community resources, and family planning;

8. patient education regarding post-abortion signs and symptoms of possible complications, activities allowed and to be avoided, hygienic and other post-

discharge procedures to be followed, telephone numbers to access emergency care, and follow-up appointments; and

9. abortion and post-abortion records.

Rules and Regulations For Abortion Facilities 2017

SECTION 10. INFECTION CONTROL FOR ABORTION FACILITIES.

A. General.

1. The facility shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in patients, and health care workers.

2. The facility shall follow standard Center for Disease Control and Prevention (CDC) precautions.

3. There shall be policies and procedures establishing and defining the Infection Control Program, including:

   (a) definitions of nosocomial infections which conform to the current CDC definitions;

   (b) methods for obtaining reports of infections in patients and health care workers in a manner and time sufficient to limit the spread of infections;

   (c) measures for assessing and identifying patients and health care workers at risk for nosocomial infections and communicable diseases;

   (d) measures for prevention of infections;

   (e) provisions for education of patients and family concerning infections and communicable diseases, including hand hygiene and isolation precautions;

   (f) plans for monitoring and evaluating all infection control policies and procedures;

   (g) techniques for:

      (1) hand hygiene including procedures for soap and water as well as alcohol based hand rub if used;

      (2) scrub technique (applies only to General Abortion Facilities);

      (3) asepsis;

      (4) sterilization;

      (5) disinfection;

      (6) housekeeping;

      (7) linen care;

      (8) liquid and solid waste disposal of both infectious and regular waste. Disposal of infectious waste shall conform to the latest

edition of the Rules and Regulations Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities;

(9) policy for disposal of products of conception;

(10) sharps and needle disposal;

(11) separation of clean from dirty processes; and

(12) other means of limiting the spread of contagion;

(h) a requirement that disinfectants, antiseptics, and germicides be used in accordance with the manufacturer's directions;

(i) employee health.

4. There shall be an orientation program for all new health care workers concerning the importance of infection control and each health care worker's responsibility in the facility's Infection Control Program.

5. There shall be a plan for each employee to receive annual in services and educational programs, as indicated, based upon assessment of the infection control process.

B. Employee Health.

1. The facility shall develop policies and procedures for screening health care workers for communicable diseases and monitoring health care workers exposed to patients with any communicable diseases.

2. There shall be policies regarding health care workers with infectious diseases or carrier states. The policies shall clearly state when health care workers shall not render direct patient care.

NOTE: Health care workers employed by the facility who are afflicted with any disease in a communicable stage, or while afflicted with boils, jaundice, infected wounds, diarrhea, or acute respiratory infections, shall not work in any area in any capacity in which there is a likelihood of such person contaminating food, food contact surfaces, supplies, or any surface with pathogenic organisms or transmitting disease to patients, facility personnel or other individuals within the facility.

3. There shall be a plan for ensuring that each health care worker has an annual tuberculosis skin test or is evaluated in accordance with current Arkansas Department of Health Rules and Regulations Pertaining to the Control of Communicable Disease - Tuberculosis.

4. There shall be a plan for ensuring that all health care workers who are frequently exposed to blood and other potentially infectious body fluids are offered immunizations for hepatitis B.

C. Reporting. Infectious and communicable diseases shall be reported to the Arkansas Department of Health in accordance with the most current versions of:

1. Rules and Regulations Pertaining to Comunicable Disease in Arkansas; and

2. the Rules Pertaining to the Control of Communicable Diseases-Tuberculosis.

SECTION 11. PHARMACEUTICAL SERVICES.

A. Organization.

1. Abortion Facilities shall have provisions for pharmaceutical services regarding the procurement, storage, distribution and control of all medications. The Abortion Facility shall be in compliance with all state and federal regulations.

2. Pharmaceutical services shall be under the direction of a licensed pharmacist if required by State law. In case the Abortion Facility does not require a licensed pharmacist, the Medical Director shall assume the responsibility of directing Pharmaceutical Services. A licensed pharmacist means any person licensed to practice pharmacy by the Arkansas State Board of Pharmacy who provides pharmaceutical services as defined in the Pharmacy Practice Act. The pharmacist or Medical Director shall make provisions that shall include, but not be limited to:

   (a) development and implementation of pharmacy policies and procedures;

   (b) annual review and revisions of pharmacy policies and procedures, with documentation of dates of review;

   (c) maintenance of medications in the Abortion Facility to meet the needs of the population served;

   (d) maintenance of medications in the Abortion Facility to ensure accountability; and

   (e) proper storage of medications.

B. Staffing. Pharmaceutical services shall be provided by a licensed pharmacist or Medical Director as required by State law. If the service is provided by a consulting pharmacist, it may be done so on a consulting basis. Onsite consultation by the pharmacist shall be required at least monthly. Documentation of each consultation visit shall be recorded and maintained at the Abortion Facility. Documentation of each visit shall include compliance with, but not be limited to:

1. proper storage of drugs;

2. disposal of medications no longer needed, discontinued, or outdated;

3. proof of receipt and administration of controlled substances and proper storage of such medications;

4. verification that medications in stock conform to the specified quantities on posted lists;

5. proper labeling; and

6. maintenance of emergency carts or kits.

If the service is under the direction of the Medical Director, he/she may designate the above required monthly documentation to a licensed nurse.

C. Policies and Procedures. There shall be pharmacy policies and procedures to include, but not be limited to:

1. detailed job description of the licensed pharmacist and/or Medical Director;
2. procurement of medications;
3. distribution and storage of medications;
4. a listing of stock medications with minimum and maximum quantities to be maintained in the Abortion Facility;
5. a listing of medications with exact quantities to be maintained in emergency kits;
6. destruction of deteriorated, non-sterile, unlabeled, or damaged medications;
7. listing controlled substances to be destroyed on the proper forms and either sending a copy of the form with the medications to the Arkansas Department of Health by registered mail or delivering the form and medications in person;
8. maintenance of all drug records for a minimum of two (2) years;
9. maintenance of medications brought to the Abortion Facility;
10. drug recalls;
11. reporting of adverse drug reactions and medication errors to the attending physician and the Governing Body;
12. accountability of controlled substances;
13. reporting of suspected drug loss, misuse, or diversion, according to state law;
14. use of Automatic Medication Dispensing Devices, if applicable.

D. Drug storage and security. Medications maintained at the Abortion Facility shall be properly stored and safeguarded to ensure:

1. locked storage of all medications;
2. proper lighting and ventilation, as required by the manufacturer;
3. proper temperature controls with daily temperature documentation of medication refrigerators to ensure storage between thirty-six (36) and forty-six (46) degrees Fahrenheit, or two (2) to eight (8) degrees Centigrade;

4. separate storage of biologicals and medications from food;

5. accessibility to licensed personnel only; and

6. proper use of any Automatic Medication Dispensing Devices.

E. Controlled Substances.

1. Controlled drugs shall be double locked.

2. A record of the procurement and disposition of each controlled substance shall be maintained in the Abortion Facility and be readily retrievable. Each entry on the disposition record shall reflect the actual dosage administered to the patient, the patient's name, date, time, and signature of the licensed person administering the medication. The signature shall consist of a first initial, last name, and title. (Licensed personnel who may legally administer controlled substances shall include only those personnel authorized by their current Practice Act and licensed by the Arkansas State Medical Board or Arkansas State Board of Nursing.) Any error of entry on the disposition record shall follow a policy for correction of errors and accurate accountability. If the licensed person who procures medication from the double locked security is not the licensed person who administers the medication, then both persons shall sign the disposition record;

3. When breakage or wastage of a controlled substance occurs, the amount given and amount wasted shall be recorded by the licensed person who wasted the medication and verified by the signature of a licensed person who witnessed the wastage. Documentation shall include how the medication was wasted. In addition to the above referenced licensed personnel, licensed pharmacists shall be allowed to witness wastage of controlled substances. When a licensed person is not available to witness wastage, the partial dose shall be sent to the Arkansas Department of Health, Division of Pharmacy Services and Drug Control for destruction;

4. There shall be an audit each shift change of all controlled substances stocked in the Abortion Facility which shall be recorded by an oncoming nurse and witnessed by an off-going nurse. If only one (1) shift exists, an audit shall be conducted at the opening and closing of the abortion facility daily. If discrepancies are noted, the Director of Nursing, Pharmacy Consultant and/or Medical Director shall be notified. As with the witnessing of wastage, licensed pharmacists shall be allowed to witness controlled substance audits;

5. Records generated by Automatic Dispensing Devices shall comply with these requirements.

F. Medications.

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1. All verbal or telephone orders for medications shall be received by a licensed nurse or Registered Pharmacist and reduced to writing into the patient's medical record. Verbal or telephone orders shall be countersigned by the practitioner within twenty-four (24) hours. Signed facsimile orders are acceptable, provided the facsimile paper is of a permanent nature.

2. The Abortion Facility may procure medications for its patients through community pharmacists, or medications may be procured through the facility's physician.

SECTION 12. PHYSICAL FACILITIES, ABORTION FACILITIES.

A. Definitions.

1. **Accessible** - barrier free; approachable by all peoples including those with physical disabilities.

2. **Addition** - an extension or increase in floor area and/or height of an existing building, or structure.

3. **Alter or Alteration** - any change(s) and modification in construction, occupancy, installation, or assembly of any new structural components, and any change(s) to the existing structural component, in a system, building, and structure.

4. **And/Or** (in a choice of two (2) code provisions) - signifies use of both provisions shall satisfy the code requirements and use of either provision is acceptable, also. The most restrictive provision shall govern. Where there is a conflict between a general requirement and a specific requirement, the specific or restrictive requirement shall be applicable.

5. **Architect** - a duly registered professional licensed by the Arkansas State Board of Architects to use the title "architect."

6. **Corridor** - a passage way into which compartments or rooms open and which is enclosed by partitions and/or walls and a ceiling, or a floor/roof deck above.

7. **Engineer** - duly registered professional licensed by the Arkansas Board of Registration for Professional Engineers and Land Surveyors to use the title "engineer."

8. **New construction** - the assembly of a new free standing structure.

9. **Renovation** - construction performed within an existing facility.

10. **Room** - a separate, enclosed space, with doorway(s), for the one (1) named function.

11. **Toilet** - a room designed exclusively for a water closet and lavatory.

B. Plan Review. Plans for all new construction and/or alterations shall include site requirements, preliminary drawings, submission of plan review fee, final construction documents, letter of approval for construction documents, site observation and final site observation.

1. No new mechanical, electrical, plumbing, fire protection, or medical gas system shall be installed, nor any such existing system materially altered or extended, until complete drawings and specifications for installation, alteration, or extensions have been submitted to the Division for review and approval.

2. Site Requirements.

(a) The site location shall be easily accessible to the community and to service vehicles such as fire protection apparatus.

(b) The Abortion Facility shall have security measures for patients, personnel, and the public consistent with the conditions and risks inherent in the location of the facility.

(c) Site utilities shall be reliable (water, natural gas, sewer, electricity and communication). The water supply shall have the capacity to provide normal usage plus fire fighting requirements. The electricity shall be of stable voltage and frequency.

(d) The site shall afford good drainage and shall not be subject to flooding.

(e) Soil bearing capacity shall be sufficient to support the building and paved areas.

(f) Paved access roads and walks shall be provided within the boundary of the property to public service and emergency entrances.

(g) Paved parking spaces shall be provided to satisfy the needs of patients, employees, staff, and visitors. In the absence of a formal parking study, each facility shall provide not less than one (1) space for each day shift staff member and employee plus one (1) space for each patient bed/recliner. Parking spaces shall be provided for emergency and delivery vehicles.

3. Preliminary Drawings. Schematic drawings for the Abortion Facility shall be submitted to the Division. These drawings shall illustrate a basic understanding of the architectural, mechanical, electrical and plumbing systems. Schematic drawings shall include schematic plans, building sections, exterior elevations (all sides), preliminary finish schedule, and general notes. Code criteria shall be submitted that is specific to the proposed facility and exhibits knowledge of the building and fire code requirements including but not limited to construction type, fire protection ratings, means of egress and smoke compartmentalization. Drawings shall be at a scale to clearly represent the intent. A graphic and/or written scale and directional arrow shall be on each drawing.

4. Submission of Plan Review Fee. A plan review fee in the amount of one (1) percent of the total cost of construction or five hundred dollars ($500.00), whichever is less, shall be paid for the review of drawings and specifications. The plan review fee check is to be made payable to the Division of Accounting, Arkansas Department of Health. A detailed estimate must accompany the plans unless the maximum fee of five-hundred dollars ($500.00) is paid. The Division will coordinate review of plans for all Arkansas Department of Health offices.

5. Final Construction Documents.

(a) Plans and specifications shall be prepared by an architect and/or engineer licensed by the State of Arkansas. The architect and engineer shall prepare and submit construction documents with the respective seals for each professional discipline. Architectural construction documents shall be prepared by an architect, and engineering (mechanical, electrical, civil and structural) construction documents shall be prepared by an (mechanical, electrical, civil and structural) engineer. Periodic observations of construction shall be provided and documented by each design professional to assure that the plans and specifications are followed by the contractor, and that "as build" prints are kept current. The interval for periodic observation shall be determined and approved by the Division prior to beginning construction.

(b) Working drawings and specifications shall be prepared in a manner that clearly defines the scope of the work and is consistent with the professional standard of practice for architects and engineers. Working drawings and specifications shall be complete for contract purposes.

(c) Final construction documents shall be reviewed and approved by the Division prior to the beginning of construction. The Division shall have a minimum of six (6) weeks to review final construction documents after which time an approval letter shall be issued. Plan review with other Health Department Divisions shall be coordinated by the Division.

6. Site Observation During Construction. The Abortion Facility shall be observed during construction and before occupancy.

(a) The Division shall be notified when construction begins and a construction schedule shall be submitted to determine inspection dates.

(b) Representatives from the Division shall have access to the construction premises and the construction project for purposes of making whatever inspections deemed necessary throughout the course of construction.

(c) Any deviation from the approved construction documents shall not be permitted until a written construction addenda or change order is approved by the Division.

7. Final Site Observation.

(a) Upon completion of construction and prior to occupancy approval by the Division, the owner shall be furnished one (1) complete set of contract documents, plans and specifications showing all construction, fixed equipment, and mechanical and electrical systems as installed or built. In addition, the owner shall be furnished a complete set of installation, operation, and maintenance manuals and parts lists for the installed equipment.

(b) No Abortion Facility shall occupy any new construction, addition, renovation and/or alteration until approval has been granted from all city, county, and other state regulatory agencies in addition to the Division.

C. General Considerations.

1. The requirements set forth herein have been established as minimum requirements for new construction, addition(s), renovation(s) and alteration(s) in Abortion Facilities requiring licensure under these regulations.

2. Abortion Facilities undertaking new construction, an addition, renovation, and/or alteration shall minimize disruption of existing functions. Access, exits and fire protection shall be maintained for occupancy safety.

3. The building and equipment shall be maintained in a state of good repair at all times.

4. The premises shall be kept clean, neat, free of litter and rubbish.

D. Codes and Standards.

1. Nothing stated herein shall relieve the owner from compliance with building, fire, subdivision and zoning codes, ordinances, and regulations of city, county and other state agencies.

2. Compliance with referenced codes and standards shall be that of the latest edition(s).

3. Accessibility requirements shall be those set forth by the Arkansas State Building Services, Minimum Standards and Criteria - Accessibility for the Physically Disabled Standards.

4. Electrical Systems. Electrical devices shall be installed in accordance with NFPA 70, National Electrical Code.

5. Mechanical Systems.

(a) HVAC systems shall be installed in accordance with the Arkansas State Mechanical Code.

(b) Air ventilation and filtering requirements shall be in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality and ASHRAE 52, Filter Efficiencies.

6. Plumbing and Gas Systems.

(a) Plumbing systems shall be installed in accordance with the Arkansas State Plumbing Code.

(b) Gas systems shall be installed in accordance with the Arkansas State Gas Code.

7. New Abortion Facilities shall meet the criteria of NFPA 101, Life Safety Code, Chapter 26, New Business Occupancies. Existing buildings proposed for use as Abortion Facilities shall meet the criteria of NFPA 101, Life Safety Code, Chapter 27, Existing Business Occupancies. Both new Abortion Facilities and existing buildings proposed for use as Abortion Facilities shall meet the following additional requirements:

(a) Emergency lighting shall be connected to rechargeable back-up (ninety (90) minute minimum duration) batteries as a means of emergency illumination for procedure rooms, corridors, stairways, exit signs and at the exterior of each exit.

(b) A protected premises fire alarm system as defined in NFPA 72, National Fire Alarm Code, Chapter 3 shall be required.

(c) Fire extinguisher(s) shall be easily accessible and shall be provided, located, and inspected as defined in NFPA 10, Standard for Portable Fire Extinguishers.

(d) At least two (2) separate exits that are remote from each other shall be provided on every story of Abortion Facility use.

(e) The minimum clear door opening for patient use shall be two (2) feet eight (8) inches.

(f) Gas fired equipment rooms shall be separated with one (1) hour fire resistance partitions.

(g) No operable fireplace shall be permitted. Inoperable fireplace(s) shall be sealed at the upper and lower portions of the flue.

(h) Cabinets or casework in patient use areas shall be furred to the ceiling above or provided with sloping tops to facilitate cleaning.

(i) A panic bar releasing device shall be provided for all required exit doors subject to patient traffic.

(j) Medical gas, air and vacuum systems, if provided, shall meet installation, testing, maintenance and certification criteria of NFPA 99, Standard for Health Care Facilities.

E. Design Considerations

1. Each Abortion Facility design shall ensure patient acoustic and visual privacy during interview, examination, treatment and recovery.

2. The premises shall be kept free from insect and vermin infestation.

3. The building shall be well ventilated at all times with a comfortable temperature maintained.

4. Space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, containment or removal, or by a combination of these techniques.

5. Waiting/Reception area(s) shall be provided with sufficient seating for the maximum number of people that may be waiting at any one (1) time. A reception and information counter or desk shall be provided.

6. A barrier free public toilet rooms shall be provided. This room may be conveniently located outside the Abortion Facility as part of shared tenant spaces in the same building.

7. Public telephone(s) shall be provided.

8. A housekeeping room with mop sink shall be provided.

9. Storage space shall be provided for both administrative and clinical needs.

10. A business office room shall be provided.

11. A medical records storage room shall be provided. This room shall protect records against undue destruction from dust, vermin, water, smoke and fire. It shall be constructed as a one (1) hour fire resistance rated enclosure and protected by a smoke detection system connected to the fire alarm. Storage for records shall be accessible and at least six (6) inches above the floor.

12. A consultation room shall be provided.

13. An examination room shall be provided. The examination room shall have a minimum floor area of eighty (80) square feet excluding fixed millwork, vestibule, toilet and closets. The room shall contain an examination table and chair, charting counter or desk, instrument table and shelves, hand-washing sink and equipment storage as needed. Room arrangement shall permit at least three (3) feet clearance at each side and at the foot of the examination table. Entry door swing and view angles shall maximize patient privacy. This room may be combined with the procedure room.

F. Interior Finishes.

1. Interior finishes shall meet the flame spread and smoke development requirements of NFPA 101, Life Safety code.

2. Finished floors, ceilings and walls shall be provided for all rooms and spaces except mechanical and electrical rooms.

3. Procedure rooms and soiled work rooms shall have a monolithic finish floor and base, stain resistant for its intended use and integral with each other (i.e., sheet vinyl floor with continuous sheet vinyl base). Seams in the monolithic floor and

base shall be chemically welded.

4. Toilet rooms, clean work rooms, housekeeping rooms and examination rooms (when combined with the procedure room) shall not have a carpeted floor finish.

5. Procedure rooms, soiled work rooms and clean work rooms shall have smooth, washable, moisture resistant, ceilings of gypsum board, plaster or mylar faced lay-in ceiling tiles.

6. Wall finishes for all rooms shall be smooth, moisture resistant and washable.

G. General Abortion Facilities: additional requirements. In addition to the preceding requirements, General Abortion Facilities shall also meet the requirements below.

1. A procedure room shall be provided. The procedure room shall have a minimum floor area of one-hundred-twenty (120) square feet excluding fixed millwork, vestibule, toilet and closets. The minimum room dimension shall be ten (10) feet. The room shall contain a handwash sink with hands-free controls, soap dispenser and single service towel dispenser.

2. One (1) or more recovery rooms shall be provided. A recovery room shall have a minimum of sixty (60) square feet per patient excluding fixed millwork, vestibule, toilet and closets. The room shall contain a bed or a washable, reclining chair. Multi-patient recovery rooms shall be provided with cubicle curtains for patient privacy.

3. A clean work room shall be provided sufficient in size to process clean and sterilize supply materials and equipment. This room shall contain a handwash sink, work counter and autoclave adequate in size to sterilize the equipment in use.

4. A soiled work room shall be provided. This room shall contain a handwash sink and work counter.

5. At least one (1) barrier free, patient toilet room shall be provided for each recovery room.

Rules and Regulations For Abortion Facilities 2017

SECTION 13. CERTIFICATION.

CERTIFICATION

It is found and determined by the Board of Health that this rule is necessary to clarify mandates placed on abortion facilities in Arkansas as a result of the passage of Act 603 of 2017. Act 603 will become effective on July 31, 2017. The Act is unclear if abortion facilities would be responsible for the disposition of dead fetuses and fetal tissue when the evacuation occurs outside the presence of the inducing physician or away from the facility in which the physician administered the inducing medications. Therefore, an emergency is hereby declared to exist and this Rule, being necessary for the immediate preservation of the public peace, health and safety, shall be in full force and effect from and after July 31, 2017.

This will certify that the foregoing revisions to the Rules and Regulations for Abortion Facilities in Arkansas 2017 were adopted by the State Board of Health of Arkansas at a special session of said Board held in Little Rock, Arkansas, on the 19th day of July, 2017.

Nate Smith, M.D., MPH
Secretary of Arkansas State Board of Health
Director, Arkansas Department of Health

Nov. 14, 2017
Date

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Health

DIVISION Center for Health Protection/Health Facilities Section

DIVISION DIRECTOR Renee Mallory

CONTACT PERSON Robert Brech

ADDRESS 4815 West Markham, St., Slot 31, Little Rock, AR

PHONE NO. 501-661-2297 **FAX NO.** 501-661-2357 **E-MAIL** robert.brech@arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Robert Brech

PRESENTER E-MAIL robert.brech@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Abortion Facilities in Arkansas

2. What is the subject of the proposed rule? Disposition of fetal tissue

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☒ No ☐
   If yes, what is the effective date of the emergency rule? 11-14-2017

   When does the emergency rule expire? 3-14-2018

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☒ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Act 603 of 2017

7. What is the purpose of this proposed rule? Why is it necessary? To clarify that abortion facilities are not responsible for fetal remains expelled away from their facilities.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
http://www.healthy.arkansas.gov/aboutADH/Pages/RulesRegulations.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: 11/13/2017
Time: 10:00
Place: Suite 801, 5800 West Tenth Street, Little Rock, Arkansas

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
11/13/2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
3/15/17

12. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain. The Department is not aware of any significant controversy at this time regarding this rule.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Health
DIVISION Center for Health Protection/Health Facilities Section
PERSON COMPLETING THIS STATEMENT Robert Brech
TELEPHONE NO. 501-661-2297 **FAX NO.** 501-661-2357 **EMAIL:** robert.brech@arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Abortion Facilities in Arkansas

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;
   N/A

   (b) The reason for adoption of the more costly rule;
   N/A

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;
   N/A

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.
   N/A

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
    (a) justifies the agency's need for the proposed rule; and
    (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
    (a) the rule is achieving the statutory objectives;
    (b) the benefits of the rule continue to justify its costs; and
    (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH	**PETITIONER**
V.	
LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS	**RESPONDENT**

RESPONDENTS' REPLY TO RESPONSE OF ADH TO APPEAL OF DEFICIENCY FINDINGS AND MOTION TO DISMISS DEFICIENCY CITATIONS

Respondents provide this reply in further support of their appeals of the March 13 and 23, 2018, Arkansas Department of Health ("ADH") Statements of Deficiencies. ADH's response does not address Respondents' numerous constitutional arguments against ADH's enforcement actions, addresses only the last few pages of Respondents' 27-page opening brief, does not contest any of Respondents' factual evidence, and concedes there are no facts in dispute. *See* Response, p.1. Respondents, therefore, reply only to ADH's limited arguments before the Arkansas Board of Health ("Board"), fully reserving all of their federal and Arkansas constitutional claims against the asserted deficiencies and the Payment Ban. As Petitioner recognizes, these constitutional claims were necessarily asserted by Respondents in order to preserve them for appeal to the Courts, *see* Response p. 2, and they are so preserved.

ADH is not authorized to issue the Statements of Deficiencies in the absence of an applicable rule.

ADH has exceeded its authority in issuing deficiency citations in the absence of a rule or regulation. In response to this contention, ADH argues, without any citation to authority, (1) that

a rule is unnecessary because the language of 1703(d) is "plain and unequivocal," *see* Response, Issue 1(e), and (2) that it has the authority to issue the deficiency citations under A.C.A. §20-9-302. *See* Response, Issue 1(a).

As Respondents established in their opening submission, ADH recognized in 2016 that it lacked the authority to cite LRFPS for charging for services before the expiration of 48 hours because ADH had not promulgated any rule or regulation regarding this conduct. *See* Appeal, Exh. B (Brech Aug. 25 letter) to Exh. 1. ADH is still without any rule or regulation attempting to implement 1703(d) ("the Payment Ban"), and its short Response fails to explain why the absence of a rule no longer impacts its authority to issue a deficiency. Its assertion that a rule is simply "unnecessary" is contradicted by ADH's own position in 2016.

ADH also errs in arguing that a rule is unnecessary because the Payment Ban purportedly involves a "remedial" statute that "require[s] a liberal construction." *See* Response 1(d). To the contrary, this case concerns abortion facility licensing penalties, and the Arkansas courts are clear that statutes imposing such penalties must be strictly construed in favor of the licenseee, not liberally construed in favor of the state. *See Wilcox v. Safley*, 298 Ark. 159, 161, 766 S.W.2d 12, 13 (1989) ("Code provisions imposing penalties for noncompliance with licensing requirements ... must be strictly construed.")

More fundamentally, the Board of Health is a statutory creation. It cannot exceed its explicit statutory authority, which is to "make all necessary and reasonable rules and regulations of a general nature for . . . the protection of the public health and safety." *See* A.C.A. §20-7-109. Petitioner is "the state agency responsible for implementing the Board's regulations." *See* https://www.healthy.arkansas.gov/rules-and-regulations.gov. A review of all laws pertaining to the creation and administration of both the Board and the department refer to its powers solely in

terms of rules and regulations. *See generally*, §25-9-101 *et. seq*. As stated in the ADH Guide to Administrative Procedure, the Arkansas State Board of Health (the "Board") and ADH are authorized by law to create and enforce **rules and regulations** to protect the health of Arkansans." Nowhere is it conferred upon ADH or the Board the power to enforce a state statute absent an appropriate rule or regulation. *See* https://www.healthy.arkansas.gov/images/uploads/pdf/AdminProcedureGuide.pdf . Moreover, in §20-16-1508, the Legislature specifically instructed the Board to "adopt rules to implement the subchapter," of which the Payment Ban is a part. Since 2015, when the Payment Ban was enacted, Petitioner has ignored this legislative mandate. Since there is no regulation implementing the Payment Ban, the deficiency citations issued to Respondents are improper and should be dismissed.

In addition, ADH's issues 1(c) and 1(f) in its Response are irrelevant and offer no support for these deficiencies. The "informed consent signatures" referenced in ADH's point 1(c) are those specified in §20-16-1703(b)(6)(a), which requires a patient to sign a check-list after receiving the information required for informed consent in Arkansas. That check-list signature requirement does not incorporate or otherwise reference the Payment Ban. Moreover, the deficiencies cited in this case were not for any missing signed forms or missing informed consent materials. *Cf.* §20-16-1703(b) & (e). Finally, the licensing statute itself requires the department to "Adopt appropriate rules . . . [for] procedures" and "informed consent signatures" to "meet statutory requirements." §20-9-302(b)(1). Despite this legislative mandate, there is no rule, appropriate or otherwise, pertaining to the Payment Ban.

ADH acted in an arbitrary and capricious manner in issuing the March 2018 deficiency citations.

In their appeals, Respondents argue that ADH's issuance of the March 2018 deficiency citations was arbitrary and capricious because a previous inspection by ADH concerning the same conduct, *see* Appeal, Exh A to Exh 1, resulted in a finding that LRFPS was in compliance with all ADH rules and regulations and state laws. *See* Appeal, p. 5. Petitioner has responded to this argument by addressing a different prior deficiency finding, which is Exh. B to Exh. 1 to the Appeal, and ignoring the finding of no deficiency shown in Exh. A to Exh. 1. *See* Response, p. 5. While the deficiency citation that is the subject of this appeal is based on the 2017 amendment to the Payment Ban's provisions, this amendment did not change the terms of the ban; it merely expanded the categories of actors who might bill for physicians' services and thus be subject to that same ban. *See* Appeal, Exh.4 and Act 383 of 2107, attached to this Reply as Exh. 1

Two separate complaints concerning the Payment Ban resulted in ADH inspections of LRFPS in 2016. The first inspection, prior to May 16, 2016, resulted in no deficiency finding. *See* Appeal, Exh. A to Exh. 1; the second was dismissed by ADH because it lacked authority to issue it —even though the physician's practice of charging for services provided at the patient's first visit at the time these services were provided was the same at both inspections. *See* Appeal, Exh. 1. If the physician's practice of charging patients before the expiration of the 48-hour reflection period violated 1709(d) in 2018, ADH should have issued a deficiency on May 16, 2016. It did not. The amendment's expansion of the Payment Ban provision to include other actors does not change the substance of the law. The only thing that changed was ADH's interpretation of the law.

In addition, even after Act 383 went into effect in August 2017, an ADH inspection in December of that year did not result in a deficiency citation for violation of the Payment Ban,

even though at that time, patients were being charged prior to the lapse of the 48-hour period. See Supplementary Affidavit of Lori Williams, attached as Exh. 2 to this Reply. So as late as December 2017, Petitioner did not consider charging at the patient's first visit to be a deficiency. Again, the only thing that changed between December 2017 and March 13, 2018, was Petitioner's interpretation of the law.

ADH's current interpretation and enforcement of 1703(d) results in nonpayment, not delay of payment for medical services.

ADH has known since its attempted citation of LRFPS for ultrasound and related billing in 2016 that much more than a "mere delay" is involved in its enforcement of the Payment Ban. *Cf.* ADH Br. Issues 2 & 3. Undisputed facts established at that time, like the undisputed record here, showed that providers are *never* paid for a huge fraction of ultrasound patients' care if payment is not collected at the time of service – as is standard in the practice of medicine and especially critical where there is no insurance or other third-party payment source. See Appeal, Exhs 1 and 2.[1] ADH recognized that such an asserted deficiency inappropriately interfered with medical providers' practice in 2016, yet ADH has now without rational explanation reversed course. But the same reasons that providers could not be so severely penalized in 2016 exist today. The legislature's addition of different categories of those who might bill for physicians' services does not change the fact that preventing payment for those services is unjustified. Enforcing deficiency notices and preventing payment now, when efforts to do so in 2016 were properly withdrawn, is arbitrary and capricious.

[1] The Payment Ban bears no resemblance to the workers' compensation system, A.C.A. 11-9-118, where workers who have made a claim for workers' compensation coverage can formally serve medical providers with notice to rely on that alternate payment scheme. In contrast, the Payment Ban imposes *loss* of payment on providers and no potential recourse to any source of payment other than patients themselves, rather than offering a *different* system for payment like workers' compensation insurance.

ADH's current interpretation and enforcement of the Payment Ban impermissibly interferes with the practice of medicine.

ADH does not respond to Respondents' argument and the evidence that demonstrates that ADH's current interpretation of the Payment Ban conflicts with A.C.A. §20-7-109, which forbids ADH and the Board from regulating the practice of medicine or interfering with patients employing the practitioner of their choice. The fact that an amendment to the Payment Ban provision was broadened to include not only physicians but the abortion facilities where they practice does not take away from the fact that its restriction on billing interferes with and impermissibly regulates the practice of medicine.

The deficiency citations issued to PPAEO's health centers for its collection of credit card information within the 48-hour waiting period must be withdrawn.

ADH also fails to address the substance of Respondents' argument that the collection of credit card information does not violate the Payment Ban, and that ADH's citation of PPAEO for collecting credit card information was arbitrary and capricious. Instead, ADH merely states the general legal principle that for an action to be arbitrary and capricious, the challenging party must show that the action is not supportable on any rational basis. Response, Issue 3.

But that is precisely what Respondents have done. Interpreting the Payment Ban as prohibiting the collection of credit card information violates the plain language of the statute, is in excess of the agency's statutory authority, and is arbitrary and capricious. A.C.A. § 25-15-212. As detailed in Respondents' opening brief, the plain language of the statute does not prohibit the mere collection of credit card information at the first visit: collecting credit card information does not constitute "requiring" or "obtaining" payment. *See* Appeal at 25-26. Petitioner fails to respond to this argument, perhaps because it is so clear that the collection of credit card information does not fall within the statutory prohibition.

Under Arkansas law, an agency interpretation of a statute will be overturned when it clearly conflicts with the statutory language. *See Ford v. Keith*, 338 Ark. 487, 494 (1999). Thus, "when the statute is not ambiguous, as is the case here, the court will not interpret a statute to mean anything other than what it says," *Simpson v. Cavalry SPV I, LLC*, 2014 Ark. 363, 8, 440 S.W.3d 335, 340 (2014), even if the agency takes a contrary view. Moreover, the Arkansas Supreme Court has been clear that "[c]ode provisions imposing penalties for noncompliance with licensing requirements ... must be strictly construed." *Wilcox*, 298 Ark. at 161. With statutes imposing penalties like the Payment Ban, "every doubt as to construction must be resolved in favor of the one against whom the enactment is sought to be applied." *Id.* Accordingly, since the deficiencies issued to PPAEO were based solely on the collection of credit card information at the first visit, they must be set aside.

ADH has tortuously interfered with PPAEO's contractual relations with its patients and sovereign immunity in no way precludes this challenge to the deficiency citations.

In response to respondents' tortious interference claim, ADH simply repeats its erroneous arguments that it has not acted arbitrarily and capriciously to interfere with medical providers' practice and compensation from their patients. In addition, it asserts that sovereign immunity precludes "a claim" for tortious interference with contract. *See* Response, Issue 5. Respondents are asserting tortious interference as a defense against these deficiencies. Moreover, there are no constitutional issues or just compensation issues now before the Board. Rather, it is properly being asked according to its own administrative procedures to reverse these deficiencies issued by ADH and prevent ADH's further enforcement of the Payment Ban in this manner. Any issues of takings, compensation, constitutional limits and broader remedies are for the courts, if ADH fails to set aside these deficiencies. Thus, ADH's citation to the Arkansas Constitution and

sovereign immunity is not applicable here and, again, ignores and distracts from ADH's failure to conduct itself coherently and within its limited powers.)

The Payment Ban, as currently interpreted by ADH, does not affect the rate of patient return for an abortion.

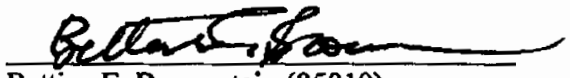
In reply to Petitioner's Issue 1(c), Respondents submit the affidavit of Mick Tilford, PhD, attached as Exhibit 3 to this Reply. Dr. Tilford's analysis of Respondents' patient data demonstrates that the Payment Ban, as currently interpreted by ADH, has no impact other than prohibiting payment for 48 hours and does not affect the likelihood that a woman will return to obtain an abortion.[2]

CONCLUSION

For the reasons asserted above, the Statements of Deficiencies should be dismissed and the Motion to Dismiss granted.

Dated: October 11, 2018

Respectfully submitted:



Bettina E. Brownstein (85019)
Bettina E. Brownstein Law Firm
904 W. Second St., Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com

[2] Dr. Tilford did not analyze the data from PPAEO since closures of PPAEo in June 2018 (due to ongoing litigation over the constitutionality of restrictions to access to abortion in Arkansas) resulted in insufficient data from PPAEO post-March 2018 for him to perform a proper analysis.

Stricken language would be deleted from and underlined language would be added to present law.
Act 383 of the Regular Session

State of Arkansas *As Engrossed: H2/10/17*
91st General Assembly **A Bill**
Regular Session, 2017 HOUSE BILL 1428

By: Representatives Lundstrum, Ballinger, Bentley, Cavenaugh, Coleman, Davis, Della Rosa, Dotson, C. Douglas, Farrer, Gates, Gonzales, Hollowell, Jett, Lowery, Lynch, McCollum, D. Meeks, Miller, Penzo, Payton, Pilkington, Richmond, Rye, B. Smith, Speaks, Warren, Watson, J. Williams
By: Senators Flippo, Bledsoe, A. Clark, B. Johnson

For An Act To Be Entitled

AN ACT TO AMEND LAWS CONCERNING UNLAWFUL ABORTIONS; TO AMEND LAWS CONCERNING THE PROCEDURE OF DENIAL, SUSPENSION, OR REVOCATION OF A HEALTH FACILITIES SERVICE LICENSE; TO AMEND THE LAWS REGARDING ABORTION CLINICS; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND LAWS CONCERNING UNLAWFUL ABORTIONS; TO AMEND LAWS CONCERNING THE PROCEDURE OF DENIAL, SUSPENSION, OR REVOCATION OF A HEALTH FACILITIES SERVICE LICENSE; AND TO AMEND THE LAWS REGARDING ABORTION CLINICS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 5-61-101 is amended to read as follows:

5-61-101. Abortion only by licensed ~~medical practitioner~~ physician.

(a) It is unlawful for any person to induce another person to have an abortion or to ~~willfully~~ knowingly terminate the pregnancy of a woman known to be pregnant with the ~~intent~~ purpose to cause fetal death unless the person is a physician licensed to practice medicine in the State of Arkansas.

(b) ~~Violation~~ A violation of subsection (a) of this section is a Class D felony.

EXHIBIT 1 To Reply

02-01-2017 08:21:17 JMB226

(3)(A) Deny, suspend, or revoke licenses on any of the following grounds:

(i) The violation of any provision of law or rule; or

(ii) The permitting, aiding, or abetting of the commission of any unlawful act in connection with the operation of the institutions.

(B)(i) If the department determines to deny, suspend, or revoke a license, the department shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(ii) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(iii)(a) The department shall issue an immediate suspension of a license if an investigation or survey determines that:

(1) The applicant or licensee is in violation of any state law, rule, or regulation; and

(2) The violation or violations pose an imminent threat to the health, welfare, or safety of a patient.

(b)(1) The department shall give the applicant or licensee written notice of the immediate suspension.

(2) The suspension of the license is effective upon the receipt of the written notice.

(iv) The denial, suspension, or revocation order shall remain in effect until all violations have been corrected.

(C) The applicant or licensee shall:

(i) Be given a fair hearing; and

(ii) Have the right to present evidence as may be proper.

(D)(i) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(ii) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

consent requirement within the Woman's Right-to-Know Act, is amended to read as follows:

(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section.

/s/Lundstrum

APPROVED: 03/06/2017

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES **RESPONDENTS**
PLANNED PARENTHOOD OF
ARKANSAS AND EASTERN OKLAHOMA dba
PLANNED PARENTHOOD GREAT PLAINS

Supplementary Affidavit of Lori Williams

My name is Lori Williams. I am over the age of 21, competent and have personal knowledge of the matters testified to herein. I submit this supplementary affidavit in the captioned matter.

1. On November 21, 2017, the Arkansas Department of Health conducted an inspection of Little Rock Family Planning Services' clinic. On December 7, 2017, it issued a letter stating that "the Red Cross was not listed on the Emergency Phone Number list as required." See December 7, 2017 letter from Beck Bennett, attached as Exh. 1. There was no deficiency citation issued for charging patients at the time of their first visit to LRFPS for an ultrasound and other services related to abortion care.

2. I reviewed the records of Little Rock Family Planning Services ("LRFPS") to determine the number of patients who visited the facility from March 2017 through August 2018 making inquiry about an abortion by month. Of those patients, I also determined the number of

EXHIBIT
2
for Reply

women who returned for an abortion during the same period of time, also by month. The results of my review are below. [1]

LRFPS Abortion/Ultrasound Data

2017	Abortions	Ultrasounds (No Shows)	Total Patients
March	273	25	298
April	193	11	204
May	204	9	213
June	211	17	229
July	194	15	209
August	176	17	193
September	194	26	220
October	151	23	174
November	162	13	175
December	201	13	214

2018

January	182	22	204
February	226	16	242
March 1-15			
After Stopped Charging for Ultrasound At First Visit			
March 2-16	151	18	169

[1] Note that a patient may have had her first visit for an ultrasound and related services in one month and her abortion in a later month.

BEFORE THE ARKANSAS BOARD OF HEALTH

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March 2-16	151	18	169

[1] Note that a patient may have had her first visit for an ultrasound and related services in one month and her abortion in a later month.

April	164	18	182
May	220	15	235
June	231	20	249
July	144	18	162
August	173	19	191

3. I am providing updated information since the date of my initial affidavit. Since March 14, 2018, the day after receipt of the Statement of Deficiencies to the date of this supplementary affidavit, 108 patients, who did not return for an abortion, were billed. Of these 10 patients have paid for their ultrasound and other services after receiving a bill. This has resulted in a total loss of $ 19,600 to LRFPS and Dr. Tvedten over this period. This loss will increase so long as § 20-16-1703(d) is in effect.

18. In addition to the loss of revenue from patients, LRFPS incurs additional expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if § 20-16-1703(d) were not in effect as now interpreted by ADH. These additional expenses are $720.00 for 40 additional hours of staff time. These additional staff expenses will increase as long as this law is in effect. Thus, the total loss to LRFPS from March 14, 2018 to the date of this supplementary affidavit is $20,320.00.

FURTHER AFFIANT SAYETH NOT

Lori Williams

State of Arkansas

County of Pulaski

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 10/8/22.

(Seal or Stamp)

BRITTNEY CAMP
MY COMMISSION # 12389627
EXPIRES: October 8, 2022
Pulaski County

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and

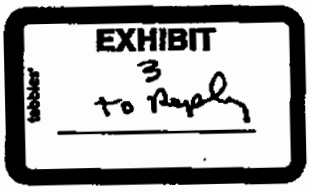
PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

AFFIDAVIT OF J. Mick Tilford, PhD

1. I am a Professor and Chair of Health Policy and Management in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences. I previously served as the Director of the Ph.D. program in Health Systems and Services Research at UAMS. I am a health economist with over 30 years of experience in this field. A copy of my curriculum vitae is attached hereto as Exhibit 1.

2. I submit this affidavit on behalf of Little Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma ("PPAEO") in the above-captioned matter.

3. I was asked to provide a statistical analysis of Ark. Code Ann. § 20-16-1703(d), and its effect on patient behavior -- more specifically to investigate whether a 48-hour or delay in payment for services provided at a women's initial visit reduces the rate at which women return for an abortion. The law states that "A physician shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section."



4. In analyzing the effect of this law, I relied on information about patient visits provided by LRFPS and data contained in the affidavit and supplementary affidavit of Lori Williams. I used all the data contained in William's supplementary affidavit. According to the information provided, at a woman's initial visit to the LRFPS clinic, she is given an ultrasound, provided with state-mandated information and materials, and if she indicates a desire to proceed with an abortion and is eligible to do so, undergoes informed-consent counselling. She is also scheduled for a procedure that occurs following the mandated waiting 48-hour waiting period.

5. I understand that before the Statement of Deficiencies was received by LRFPS on March 14, 2018, LRFPS collected payment for services provided at the first visit at that visit. I understand that after the Statement of Deficiencies was received, LRFPS ceased collecting payment for services provided at the first visit until at least 48 hours had passed.

6. To evaluate whether this change in payment practices impacted the likelihood of a woman obtaining an abortion, I compared data from before and after the Statement of Deficiencies was received by LRFPS.

7. To perform a statistical analysis, data were provided from LRFPS on women who made an initial visit to an abortion provider both before and after the Statement of Deficiencies was received. The analysis compares the percentage of women that returned for an abortion in these pre and post periods. Because LRFPS stopped accepting payment from women at the initial visit the day after receiving a deficiency citation from ADH on March 14, 2018, data from the second half of March is included in the analysis as the post-policy period for LRFPS. To address this data issue, the analysis was repeated with the month of March, 2018, excluded. The initial test of significance is based on a t-test under the hypothesis that the percentage of return visits is reduced due to the law's prohibition on charging for initial visit services until the lapse of at least

48 hours. This analysis does not control for trend. If return visits are trending upward or downward, simple pre-post comparisons provide misleading estimates as the analysis captures the influence of trend and the change in LRFPS' practice. Therefore, I have done an analysis that does control for trend, reflected in Table 3.

8. Table 1 provides an analysis of the mean return rate before and after the LRFPS' change in practice went into effect in March of 2018. The percentage of women returning for an abortion stayed approximately constant in this analysis with 91.88% returning in the period prior to the policy compared to 90.76% in the period after the policy. The difference in rates for the pre and post Statement of Deficiencies periods for the LRFPS is positive and small, leading to an insignificant finding which supports the conclusion that whether payment is required at the first visit, or payment obtained until after the lapse of 48 hours, has no effect on a woman's decision to return for an abortion.

Table 1. Before and After Comparison Using All Data Points

Statistic	Percentage Returning	Std. Err.
Mean (Before Policy)	91.88%	0.008
Mean (After Policy)	90.76%	0.007
Difference	0.0112	0.012
t-value	0.9267	
p-value	0.1839	

9. Table 2 provides a similar analysis with the exception that the month of March is excluded. In this analysis, the percentage of women returning for an abortion remains similar,

with less than a 1 percentage point reduction in the months following the policy. The small difference in the percentage returning is not significant (p= 0.2663) at conventional levels (p=0.05) and the hypothesis that the policy led to a reduction in return visits would not be supported.

Table 2. Before and After Comparison Using All Data Points Except March 2018

Statistic	Percentage Returning	Std. Err.
Mean (Before Policy)	91.88%	0.008
Mean (After Policy)	91.04%	0.008
Difference	0.008	0.013
t-value	0.6388	
p-value	0.2663	

10. Table 3 provides results from an ordinary least squares (OLS) regression analysis that allows for trends in return visits to be controlled. OLS regression is a standard statistical technique often referred to as multiple regression in that it allows for an analysis of a dependent variable (percentage of women returning) in relation to several independent variables (trend and policy period). In multiple regression, the effect of the policy period is estimated holding trend constant or controlling for trend. All of the data points were used in this analysis. The trend variable was negative suggesting that return visits were trending down over the study period, but the variable was not significant. If return visits were trending down, a pre-post analysis would indicate a decline in return visits even in absence of the law. After controlling for trend, the estimate of the policy effect was positive with almost a 1 percentage point increase in return

visits after LRFPS' change in practice. . However, the test of significance was again not supported (failed to reject the null hypothesis by not reaching conventional p-values for significance such as 0.05) suggesting that the law had no effect on return visits.

Table 3. Before and After Comparison Using All Data Points and Accounting for Trend

Statistic	Coefficient	Std. Err.	t-value	p-value
Trend Variable	-0.002	0.002	-1.01	0.328
Pre/Post Dummy	0.008	0.022	0.36	0.725
R^2	0.112			

11. Table 4 provides results from another ordinary least squares regression analysis that excludes the month of March. Again, the trend variable is negative, similar in magnitude and statistically insignificant. The estimate of the change in LRFPS' practice was positive in this analysis, but still small and statistically insignificant. This analysis also suggests that the policy had no effect on return visits.

Table 4. Before and After Comparison Using All Data Points Except March and Accounting for Trend

Statistic	Coefficient	Std. Err.	t-value	p-value
Trend Variable	-0.002	0.002	-1.17	0.262
Pre/Post Dummy	0.016	0.024	0.65	0.529
R^2	0.113			

12. Using standard statistical analysis, I find no evidence that the rate of return visits changed due to LRFPS' change in practice. Based on the data and economic analysis, the prohibition on

payment for a 48-hour period after for the initial visit has no impact on whether or not a woman returns for an abortion. The percentage of women that made an initial visit and then returned for an abortion is approximately 91% and this percentage did not change over the pre and post periods studied. The finding holds based on simple statistical tests of differences and after controlling for trend.

FURTHER AFFIANT SAYETH NOT

J. Mick Tilford

State of Arkansas
County of ~~Pulaski~~ Saline

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 09-01-2026. (Seal or Stamp)

BELINDA C. SHELTON
Notary Public-Arkansas
Saline County
My Commission Expires 09-01-2026
Commission # 12698609

CURRICULUM VITAE

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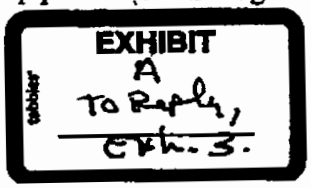
I. BIOSKETCH AND PROFESSIONAL ACCOMPLISHMENTS

John "Mick" Tilford currently serves as a Professor and Chair of Health Policy and Management in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences. Dr. Tilford also served as the Director of the Ph.D. program in Health Systems and Services Research at UAMS from 2012-2015. He has a secondary appointment in the Division of Pharmaceutical Evaluation and Policy in the College of Pharmacy and an appointment as a Senior Analyst at the Arkansas Foundation for Medical Care to assist with program evaluation. Dr. Tilford teaches courses in health economics and variations in health system performance to students in PhD and master's level programs. His research program focuses on methods for the economic evaluation of health services. He has studied the cost-effectiveness of improving outcomes in children with traumatic brain injuries, quality of care associated with intensive care units, and quality-adjusted life years in children with chronic conditions, especially children with autism. A recent area of interest has been the development of methods for incorporating family effects in economic evaluations. He received his Ph.D. in health economics from Wayne State University (1993) with the assistance of a dissertation grant from the Agency for Health Care Policy and Research (now AHRQ).

As the Chair for the Department of Health Policy and Management, Dr. Tilford worked to improve the educational programs within the department. The PhD program in Health Systems and Services Research changed from a part-time program to a full time program admitting at least two students per year with stipends. The increase in PhD students led to an increase in the number of grant submissions by faculty and publications by students and faculty.

The MHA program (under the direction of Steve Bowman initially and now Rick Ault) changed dramatically by focusing on integrating the program with the UAMS clinical enterprise and other health systems in the state. Dr. Tilford negotiated a fellowship position with the UAMS hospital CEO that led to a large increase in fellowship placements throughout the enterprise. The program



has placed students in all of the major health systems in central Arkansas including Baptist Health System and Saint Vincent Infirmary. Through these placements and strategic plans to integrate teaching and clinical activities, student performance increased markedly as witnessed by the increase in students being placed in nationally competitive fellowships including the Cleveland Clinic, Houston Methodist Hospital, the American College of Healthcare Executives, and Arkansas Children's Hospital. Enrollment in the MHA program has grown with record cohorts being admitted in recent years.

To improve the MPH program, Dr. Tilford expanded the types of preceptorships available to students. Students in the MPH program have been placed to work on implementing patient-centered medical homes through the Arkansas Medicaid program, implementing provider led payment reform through the Arkansas Department of Human Services, implementing traumatic brain injury surveillance programs within the Arkansas Spinal Cord Commission and most recently, working on implementing new personnel systems in the UAMS department of human resources.

Dr. Tilford and Mr. Ault led the development of a collaboration with the Walton College of Business at the University of Arkansas to create a healthcare track within their Executive MBA program. The first cohort of students started in the summer of 2017. He has received approval from the Arkansas Department of Higher Education to create a certificate program in analytics to start in the fall of 2018.

II. EDUCATION

Ph.D.	Economics	Wayne State University	1993
M.A.	Economics	Central Michigan University	1985
B.S.	Business & Economics	Central Michigan University	1982

Major Field: Health Economics.
Minor Field: Industrial Organization.

III. ACADEMIC AND PROFESSIONAL POSITIONS

2013 – present	Chair, Department of Health Policy and Management, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences.
2012 – 2015	Director, Doctor of Philosophy in Health Systems Research Program, College of Public Health, University of Arkansas for Medical Sciences.
2014 – 2015	Leadership Council, Translational Education Center of the Translational Research Institute, University of Arkansas for Medical Sciences.
2011 – 2014	Co-Director, Comparative Effectiveness Research Component of the Translational Research Institute, University of Arkansas for Medical Sciences.

2010 – present	Professor, Department of Health Policy and Management, College of Public Health, University of Arkansas for Medical Sciences (Primary Appointment as of 6/09).
2014 – present	Professor, Division of Pharmaceutical Evaluation and Policy, College of Pharmacy, University of Arkansas for Medical Sciences (Secondary Appointment).
2009 – 2014	Associate Professor, Division of Pharmaceutical Evaluation and Policy, College of Pharmacy, University of Arkansas for Medical Sciences (Secondary Appointment).
2008 – present	Senior Analyst, Arkansas Foundation for Medical Care, Little Rock, Arkansas.
2002 – 2010	Associate Professor, Department of Health Policy and Management, College of Public Health, University of Arkansas for Medical Sciences (Primary Appointment as of 6/09).
2000 – 2009	Associate Professor, Department of Pediatrics, University of Arkansas for Medical Sciences.
2002 – 2005	Faculty (part time), Department of Health Services Administration, University of Arkansas - Little Rock.
1999 – present	Graduate Faculty, University of Arkansas for Medical Sciences, Division of Biometry.
1994 – 2000	Assistant Professor, Department of Pediatrics, University of Arkansas for Medical Sciences.
1993 – 1994	Instructor, Department of Pediatrics, University of Arkansas for Medical Sciences.
1988 – 1992	Graduate Research Assistant, Department of Economics, Wayne State University.
1986 – 1988	Graduate Assistant, Department of Economics, Wayne State University.
1985 – 1986	Instructor, Department of Economics, University of Minnesota – Duluth.
1983 – 1985	Graduate Assistant, Department of Economics, Central Michigan University.
1982 – 1983	Instructor, Jackson Community College (State Prison of Southern Michigan).

IV. FUNDED RESEARCH AND CONTRACTS

A. Currently Active Research

1. Centers for Disease Control and Prevention. "Arkansas Prevention Research Center for Cardiovascular Risk (HTN) Reduction. Entire Period of Support 9/30/2014-9/29/2019.

2. National Institutes of Health, National Center on Minority Health Disparities, "Weight Loss and Maintenance for Rural, African American Communities of Faith (The WORD)." Co-Investigator with 5% effort (K. Yeary, PI). Entire period of support 9/12 -- 8/17.

B. Currently Active Contracts

1. Arkansas Center for Health Improvement. "Evaluation of the Arkansas Medicaid Expansion through the Private Option." (Joseph Thompson, PI). Entire Period of Support 9/14-8/19.

C. Completed Research and Contracts

1. Healogics. "Evaluation of Prior Authorization Rules on the Use of Hyperbaric Oxygenation and Outcomes for Patients with Severe Leg Wounds." Principal Investigator. Entire period of support 6/17 – 8/17.

2. National Institute of Mental Health, "Mapping Clinical Outcomes to Preference-based Measures from the NDAR Database," Co-Investigator and Mentor (N Payakachat, PI). Entire period of support: 1/14-12/15.

3. Arkansas Insurance Department. "Evaluation of the Arkansas Marketplace Health Insurance Exchange." Principal Investigator. Entire Period of Support 1/14 – 6/15.

4. National Institutes of Health, "Remote Food Photography for the Real-time Measurement of Children's Food Intake," Co-Investigator with 6% effort (C. Martin, PI). Entire period of support 4/11-3/12.

5. National Institutes of Health, "Arkansas Center for Clinical and Translational Research," Co-Director of Translational Education Component with 10% effort (L. James and C. Beck, PIs). Entire period of support 9/11 – 3/15.

6. National Institutes of Health, "Reducing Asthma Disparities through School-Based Telemedicine for Rural Children." Co-Investigator with 5% effort (Tamara Perry, PI). Entire period of support 6/10 – 5/14.

7. Centers for Disease Control and Prevention, "Enhanced Academic Detailing to Increase Immunization Recall Rates," Co-Investigator with 5% effort (J. Gary Wheeler, PI). Entire period of support 9/10-8/14.

8. Arkansas Minority Health Commission. "Economic Cost of Racial and Ethnic Health Disparities." Principal Investigator. Entire period of support 9/13 – 4/14.

9. Arkansas Spinal Cord Commission. "Post-Acute Care Costs for Brain Injuries, Spinal Cord Injuries, and Amputations in Arkansas." Principal Investigator using Arkansas Foundation for Medical Care. Entire period of support 7/12 – 6/13.

10. National Institute of Mental Health, "Measuring Quality Adjusted Life Years in Children with Autism Spectrum Disorders," Principal Investigator with 40% effort (Karen Kuhlthau, Co-PI). Entire period of support: 9/09-8/12. Total Amount: $889,603.

11. National Institute of Mental Health, "Measuring Quality Adjusted Life Years in Children with Autism Spectrum Disorders - Supplement," Principal Investigator with 5% effort (Karen Kuhlthau, Co-PI). Entire period of support: 6/10-5/12. Total Amount: $89,708.

12. Arkansas Department of Human Services, Division of Aging and Adult Services. Contract to Assess Balancing Incentives associated with the Accountable Care Act. Principal Investigator with 10% effort. Entire period of support 1/12 – 6/12.

13. National Institute of Drug Abuse, "Development and Efficacy Test of Computerized Treatment for Marijuana Dependence," Co-Investigator with 5% effort (Alan Budney, PI). Entire period of support 7/10 – 6/12.

14. National Institute on Alcohol Abuse and Alcoholism, "Family Based Contingency Management for Adolescent Alcohol Abuse," Co-Investigator with 5% effort (Cathy Stanger, PI). Entire period of support 7/07 – 6/11.

15. National Institute of Drug Abuse, "Behavioral treatment of Adolescent Marijuana Abuse," Competing Continuation for R01-DA15186, Co-Investigator with 5% effort (Alan Budney, PI). Entire period of support 7/07 – 6/10.

16. Center for Clinical and Translational Research, University of Arkansas for Medical Sciences, "Clinical Indicators to Inform Clinicians' Referral Decisions for Cardiovascular Evaluation in Women." Co-Investigator with 1% contributed effort, (Jean McSweeney, PI).

17. Arkansas Biosciences Institute, "Center of Excellence in Child Health Services Research," Co-investigator with 5% effort (James Robbins, PI). Entire period of support 7/07 – 6/08. The objective of this study was to create a central resource for investigators in the department of pediatrics to use in order to advance child health services research.

18. Children's University Medical Group, "A Hospital Data Resource and Analysis Center," Principal Investigator with no effort. This intramural project provided funds to support projects using the Healthcare Cost and Utilization Project (HCUP) database with faculty and fellows in the department of pediatrics.

19. Arkansas Children's Hospital, "Office of Health Care Research," Co-Investigator with 20% effort. (James Robbins, PI). Entire period of support: 6/94 – 6/09. The objective of this program was to provide services to ACH for the analysis of quality improvement projects.

20. Centers for Disease Control and Prevention – AAMC. "Using the HCUP Databases to Study Birth Defects," Co-investigator with 15% effort. (James Robbins, PI). Entire

period of support 10/03 – 8/07. The objectives of this study were to evaluate the birth incidence, cost, and outcomes of children born with birth defects.

21. Children's Sentinel Nutrition Project, "Cost Analysis for Hospitalizations," Co-Investigator with 5% effort (James Robbins, PI). Entire period of support 2/07 – 8/07. This small study provided support to assess whether children with food insecurity were associated with increased costs of hospitalization.

22. Centers for Disease Control and Prevention, "Health State Preference Scores and Productivity Costs for Caregivers of Children with Craniofacial Anomalies," Principal Investigator with 15% effort. Supplement to "Cooperative Agreement to Establish a Center of Excellence in Birth Defect Prevention," (Charlotte Hobbs, PI). Entire period of support 8/05 – 9/07. This project compared methods for incorporating caregiver impacts in economic evaluations of interventions to prevent or treat craniofacial birth defects.

23. Families USA (Contract), "Hospitalizations of Uninsured Children," Principal Investigator with 15% effort. Entire period of support 3/06 – 12/06. This study was the first contract received after creating a hospital data resource and analysis center. The objective was to compare outcomes of hospitalized children that lacked health insurance. A policy brief based on the study was produced by Families USA. Findings from the study were used on the US Senate floor to defend the continuation of the S-CHIP program.

24. Centers for Disease Control and Prevention – AAMC. "Health Effects of Congenital Hearing Loss in Children," Principal Investigator with 15% effort. Entire period of support 10/03 – 9/06. The purpose of this study was to generate data on quality adjusted life years in a cohort of children with hearing loss that were diagnosed prior to the advent of universal newborn hearing screening. This is the only data on QALYS in children with hearing loss in the US prior to universal newborn screening. Future research may investigate whether QALY relationships have changed following the introduction of universal newborn hearing screening.

25. Maternal and Child Health Bureau (HRSA). "Economic Evaluation of Intensive Care Services for Pediatric Traumatic Brain Injury Patients," Principal Investigator with 40% effort. Entire period of support 3/01 – 2/05. The purpose of this study was to conduct a cost-effectiveness analysis of technological change in the treatment of traumatic brain injury. HCUP data were used to generate an estimate of survival change associated with improved technology. QALY data and other cost data were collected from 10 pediatric intensive care units located across the country. The project received a national hero's award from the Emergency Medical Services for Children program.

26. Centers for Disease Control and Prevention, (DHHS) "Cooperative Agreement to Establish a Center of Excellence in Birth Defect Prevention," Co-Investigator with 15% effort. (Charlotte Hobbs, PI). Entire period of support: 10/97 –10/03. This grant established a large case-control study of birth defects. The study included a health services team to study costs and outcomes of birth defects.

27. University of California - Los Angeles. "Cost Analysis for Care of Children in the Emergency Department: Guidelines for Preparedness," Subcontract with 10% effort. Entire period of support 2/02 – 12/02. This subcontract was awarded to develop cost estimates associated with preparedness for pediatric emergencies.

28. DHHS – Arkansas. "Evaluation of the Family Planning Waiver," Co-Investigator with 5% effort. Entire period of support 3/01 – 12/04. My role on this study was to set up a system to calculate budget impacts of the family planning waiver.

29. Agency for Healthcare Research and Quality, (DHHS) "Developing an Asthma Management Model for Head Start Children," Co-Investigator with 10% effort. (Perla Vargas, PI). Entire period of support: 9/00 –8/03. This randomized controlled trial examined a case management model in young children. My role was to evaluate the costs of the intervention.

30. Agency for Health Care Policy and Research, (DHHS), R01 HS09055, "Quality and Cost Containment in Pediatric Intensive Care," Principal Investigator with 35% effort. (Debra Fiser, Co-PI). Entire period of support: 9/95 – 8/99. (Funded on initial submission). This study addressed the question of whether race or insurance influenced the allocation of pediatric intensive care services. The study collected data on over 5,000 subjects from pediatric intensive care units located nationally. We found significant differences in treatment and outcome by insurance, but not by race. Findings from the study also were used in the development of guidelines for the management of pediatric traumatic brain injury.

31. Agency for Health Care Policy and Research, (DHHS), R01 HS09055, "Quality and Cost Containment in Pediatric Intensive Care – Administrative Supplement," Principal Investigator with 5% effort. (Al Torres, Co-PI). Entire period of support: 4/97 – 9/99. The supplement was awarded to extend analysis of intensive care unit cost and outcomes to the hospital setting.

32. Maternal and Child Health Bureau – Health Resources and Services Agency, (DHHS), "Outcomes Assessment in Pediatric Trauma Patients," Co-Investigator with 5% effort. (Mary Aitken, PI). Entire period of support: 9/97 – 8/99. This study examined outcomes of children following injury.

33. Office of Rural Health Policy – Health Resources and Services Agency, (DHHS), "Arkansas Telehealth: Taking the Distance out of Caring," Co-Investigator with 15% effort. (Ann Bynum, PI). Entire period of support: 9/97 – 9/99. This study was a federal initiative to evaluate telemedicine services. My role in the project was to direct the local evaluation.

34. American Association for Respiratory Care, "Respiratory Care Practitioner-Controlled Ventilator Weaning of Children," Co-Investigator with 5% effort. (Submitted with Al Torres, PI, Directed with Mark Heulitt, PI). Entire period of support: 7/98 – 6/99. This project was a randomized controlled trial to test whether the use of respiratory care

practitioners were better able to assess weaning from mechanical ventilation and reduce the amount of time on the ventilator and the length of stay in the hospital.

35. Housing and Urban Development, "Get Smart: Health Insurance in the Delta," Co-Investigator with 20% effort. (James Robbins, Director of Evaluation), Entire period of support: 9/93 – 1/97. This project received funds to provide health insurance to previously uninsured children in the Mississippi delta.

36. Rural Utilities Service – Department of Commerce, "Arkansas Rural Medlink," Co-investigator with 20% effort. (Charles Cranford, PI). Entire period of support: 5/95 – 4/96. Served as the evaluator for this project that sought to increase access to telemedicine in rural Arkansas.

37. MCPG/CUMG research fund. "Estimation of Offset Effects Between Prescription Drug Use and Expenditures on Hospital and Ambulatory Care Visits," Co-Principal Investigator. (James Robbins, Co-PI). Entire period of support 3/95 – 4/96. This internally funded study examined whether prescription drug offsets could be estimated from the National Medical Expenditure Survey.

38. Michigan Health Care Education and Research Foundation, Grant No. 087-SAP/92-09, "Cigarette Smoking Behavior and Potential Health Care Savings in the State of Michigan," Principal Investigator. Entire period of support: 9/92 – 5/93. This grant was secured as a graduate student to estimate expenditure functions for a statistical person. It was completed while writing my dissertation.

39. Agency for Health Care Policy and Research, R03 HS07554 "Access to Medical Care and the Demand for Medical Care," Principal Investigator with 100% effort (Dissertation Grant). Entire period of support: 9/92 – 11/93.

Total Funding as Principal Investigator is approximately $4,250,000 as of 1/1/14.

D. Submitted and In-preparation Research Proposals

1. American Heart Association, "Comparative Effectiveness of Workplace Wellness Programs," Principal Investigator. Entire period of support: 1/13 – 12/14. Not Funded.

2. National Institutes of Health, "Center of Excellence Network for Comparative Effectiveness Research in Autism Spectrum Disorders," Co-Principal Investigator (with Karen Kuhlthau). Entire period of support: 7/12 – 6/17. Not Funded

3. National Institutes of Health, "Incentives and Motivational Therapy for Teens with Poorly Controlled Type 1 Diabetes," Co-Investigator (C. Stanger, PI). Entire period of support: 7/12 – 6/17. Not Funded

V. TRAINING GRANTS

A. Funded Training Grants

1. MCPG/CUMG research fund, "Research Skills Course," Principal Investigator. (Paula Roberson, Co-PI). Entire period of support: 7/96 – 6/98. This project used internal funding to provide a course to junior faculty and fellows on research skills.

2. Glaxo Inc. "Educational Grant for the Creation of a Research Skills Course," Co-Principal Investigator. (Paula Roberson, Co-PI). Entire period of support 2/94 – 5/94. This industry sponsored grant was used to fund the Research Skills Course that was given to fellow and junior faculty before the creation of the COPH.

B. Submitted Training Grants

1. Agency for Healthcare Research and Quality, "Arkansas Patient Centered Outcomes Research Scholars Program," Principal Investigator. Entire period of support 1/14-12/19. This application seeks to create a K12 institutional training program in comparative effectiveness research using patient centered outcomes. Not Funded.

VI. PUBLICATIONS

A. Peer Reviewed Journal Publications

1. Hsueh-Fen Chen, **J. Mick Tilford**, Fei Wan, Robert Schuldt. "CMS HCC Risk Scores and Home Health Patient-Experience Measures." Forthcoming in the *American Journal of Managed Care*.

2. Michael Preston, Glen Mays, Zoran Bursac, Billy Thomas, Jonathan Laryea, **J. Mick Tilford**, Michelle Odlum, Sharla Smith, Ronda Henry-Tillman. "Insurance Coverage Mandates: Impact of Physician Utilization in Moderating Colorectal Cancer Screening Rates." *American Journal of Surgery*. Epub 2018 March.

3. Clare C. Brown, **J. Mick Tilford**, T. Mac Bird. "Improved Health and Insurance Status among Cigarette Smokers After Medicaid Expansion: 2011-2016." *Public Health Reports*. Epub 2018 Jan.

4. Marcia A. Byers, Patricia Wright, **J. Mick Tilford**, Lynn S. Nemeth, Ellyn Matthews, Anita Mitchell. "Comparing Smoking Cessation Outcomes in Nurse-led and Physician-led Primary Care Visits," *J Nurs Care Qual*. 2017. EPub 2017 Sep 29.

5. Payakachat N, **J. Mick Tilford**, Kuhlthau K. "Parent-reported Use of interventions by toddlers and preschoolers with autism spectrum disorder." *Psychiatric Services*. Epub 2017 Oct 16.

6. Hsueh-Fen Chen, Saleema Karim, Fei Wan, Adrienne Nevola, Michael E. Morris, T. Mac Bird, **J. Mick Tilford**. "Financial Performance of Hospitals in the Mississippi Delta Region

under the Hospital Readmission Reduction Program and Hospital Value-based Purchasing Program. *Medical Care.* 2017 55(11): 924-930.

7. Hsueh-Fen Chen, Adrienne Nevola, Tommy M. Bird, Saleema A. Karim, Michael E. Morris, Fei Wan, **J. Mick Tilford**. "Understanding Factors Associated with Readmission Disparities among Delta Region, Delta State, and Other Hospitals." Forthcoming in the *American Journal of Managed Care.*

8. Leanne M Redman, L. Anne Gilmore, Jeffrey Breaux, Diana M Thomas, KarenElkind-Hirsch, Tiffany Stewart, Daniel S Hsia, Jeffrey Burton, John W Apolzan, Loren E Cain, Abby D Altazan, Shelly Ragusa, Heather Brady, AllisonDavis, **J. Mick Tilford**, Elizabeth F Sutton, Corby K Martin. "A novel e-Health intervention can deliver an intensive lifestyle intervention to pregnant women with pre-pregnancy overweight and obesity for management of gestational weight gain: a randomized controlled pilot study." *JMIR Mhealth Uhealth.* 2017 5(9): e133.

9. Kristina L. Bondurant, J. Gary Wheeler, Zoran Bursac, Tereasa Holmes, **J. Mick Tilford.** "Comparison of Office-Based Versus Outsourced Immunization Recall Services." *Clinical Pediatrics*, 2017 Jun;56(6):555-563.

10. Pratik Doshi1, **J. Mick Tilford**, Songthip Ounpraseuth, Dennis Z. Kuo, Nalin Payakachat. "Do Insurance Mandates Affect Racial Disparities in Outcomes for Children with Autism?" *Matern Child Health J.* 2017 Feb;21(2):351-366

11. Alesia Ferguson, Christopher Yates, **J. Mick Tilford.** "Value Based Insurance Designs in the Treatment of Mental Health Disease." *American Journal of Managed Care.* 2016 Jan 1;22(1):e38-44

12. Scott D. Grosse, Robert J Berry, **J Mick Tilford,** James E Kucik, Norman J Waitzman. "Retrospective Assessment of the Cost Savings of Prevention: Folic Acid Fortification and Spina Bifida in the United States." *American Journal of Preventive Medicine.* 2016 May;50(5 Suppl 1):S74-80

13. Nalin Payakachat, **J. Mick Tilford,** Wendy Ungar. "National Database for Autism Research (NDAR): Big data opportunities for health services research and technology assessment." *Pharmacoeconomics.* 2016 Feb;34(2):127-38.

14. **J. Mick Tilford,** Nalin Payakachat, Karen Kuhlthau, Jeffrey M. Pyne, Erica Kovacs, Jayne Bellando, D. Keith Williams, Werner Brouwer, Richard Frye. "Treatment for Sleep Problems in Children with Autism and Caregiver Spillover Effects." *Journal of Autism and Developmental Disorders.* 2015 Nov;45(11):3613-23.

15. Nalin Payakachat, **J. Mick Tilford** "Can The EQ-5D Detect Meaningful Change? A Systematic Review" *Pharmacoeconomics.* 2015 Nov;33(11):1137-54.

16. Sharla Smith, Glen Mays, **J. Mick Tilford**, Holly Felix, Geoff Curran, Michael Preston. Impact of Economic Constraints on Public Health Delivery System Structures. *AM J Pub Health.* 2015 Sep;105(9):e48-53

17. Alan J. Budney, Catherine Stanger, **J. Mick Tilford**, Pamela C. Brown, Zhongze Li, Zhigang Li, and Denise Walker. "Computer-assisted Behavioral Therapy and Contingency Management for Cannabis Use Disorder." *Psychology of Addictive Behaviors.* 2015 Sep;29(3):501-11.

18. **J. Mick Tilford** and Nalin Payakachat, "Progress in Measuring Family Spillover Effects for Economic Evaluations." Expert Reviews in Pharmacoeconomics and Outcomes Research. 2015 Apr;15(2):195-8.

    Cited in Chapter 7 of the 2nd US Panel recommendations for conducting CEA.

19. Barbara S. Saunders, **J. Mick Tilford**, Jill J. Fussell, Eldon G. Schulz, Patrick H. Casey and Dennis Z. Kuo. "Financial and Employment Impact of Intellectual Disability on Families of Children with Autism." *Families, Systems, and Health.* 2015 Mar;33(1):36-45.

20. Karen Hye-cheon Kim, Carol Cornell, T Elaine Prewitt, Zoran Bursac, **J. Mick Tilford**, Jerome Turner, Kenya Eddings, Sharhonda Love, Kimberly Harris. The WORD (Wholeness, Oneness, Righteousness, Deliverance): Design of a randomized controlled trial testing the effectiveness of an evidence-based weight loss and maintenance intervention translated for a faith-based, rural, African American population using a community-based participatory approach. *Contemporary Clinical Trials.* 2015 Jan;40:63-73.

21. Nalin Payakachat, **J. Mick Tilford**, Karen A. Kuhlthau, N. Job van Exel, Erica Kovacs, Jayne Bellando, Jeffrey M. Pyne, Werner BF Brouwer. "Predicting Health Utilities for Children with Autism Spectrum Disorders." *Autism Research.* 2014 Dec;7(6):649-63.

22. Karen Kuhlthau, Nalin Payakachat, Jennifer Delahaye, Jill Hurson, Jeffrey M. Pyne, Erica Kovacs, and **J. Mick Tilford**. "Quality of Life for Parents of Children with Autism Spectrum Disorder for Use in Cost-effectiveness Evaluations." *Research on Autism Spectrum Disorders.* 2014 Oct; (8)10:1339–1350

23. Renske Hoefman, Nalin Payakachat, Job van Exel, Karen Kuhlthau, Jeffrey Pyne, and **J. Mick Tilford**. "Caring for a Child with Autism Spectrum Disorder and Parents' Quality of Life: Application of the CarerQoL." *Journal of Autism and Developmental Disorders.* 2014 Aug;44(8):1933-45.

24. Priya Mendiratta, Parthak Prodhan, **J. Mick Tilford**, and Jeanne Wei. "Trends in Percutaneous Endoscopic Gastrostomy Placement in the Elderly from 1993-2003." *American Journal of Alzheimers Disease & Other Dementias,* 2012 Dec; 27(8): 609-613.

25. Nalin Payakachat, **J. Mick Tilford**, Erica Kovacs, Karen Kuhlthau. "Autism Spectrum Disorders: A Review of Measures for Clinical, Health Services, and Cost-Effectiveness

Applications." *Expert Reviews of Pharmacoeconomics and Outcomes Research*, 2012 Aug;12(4):485-503.

26. **J. Mick Tilford**, Nalin Payakachat, Erica Kovacs, Jeffrey M. Pyne, Werner Brouwer, Todd Nick, Jayne Bellando, Karen Kuhlthau. "Preference-based Health-related Quality of Life Outcomes in Children with Autism Spectrum Disorders: A Comparison of Generic Instruments." *Pharmacoeconomics*, 2012 Aug 1; 30(8): 661–679..

27. Rebecca A. Krukowski, **J. Mick Tilford**, Jean Harvey-Berino, Delia Smith West. "Comparing Behavioral Weight Loss Modalities: Incremental Cost-effectiveness of an Internet-based versus an In-person Condition." *Obesity*, 2011 Aug;19(8):1629-35.

28. Nalin Payakachat, **J. Mick Tilford**, Werner Brouwer, Job Van Exel, Scott D. Grosse. "Measuring Health and Well-being effects in Family Caregivers of Children with Craniofacial Malformations. *Quality of Life Research*, 2011 Nov;20(9):1487-95.

29. Dennis Z. Kuo, T. Mac Bird, **J. Mick Tilford.** "Associations of Family-Centered Care with Health Outcomes for Children with Special Health Care Needs." *Maternal and Child Health Journal*, 2011 Aug;15(6):794-805.

30. Scott D. Grosse, Alina L. Flores, Lijing Ouyang, James M. Robbins, **John M. Tilford.** "Impact of Spina Bifida on Parental Caregivers: Findings from a Survey of Arkansas Families," *Journal of Child and Family Studies*, 2009 Oct;18(5): 574-581.

31. Priya Mendiratta, **John M. Tilford,** Parthak Prodhan, Mario A. Cleves, and Jeanne Y. Wei. "Trends in Hospital Discharge Disposition for Elderly Patients with Infective Endocarditis: 1993-2003." *Journal of the American Geriatrics Society,* 2009 May;57(5):877-81.

32. **John M. Tilford,** Scott D. Grosse, Allen C. Goodman, and Kemeng Li. "Labor Market Productivity Costs for Caregivers of Children with Spina Bifida: A Population-Based Analysis." *Medical Decision Making,* 2009; Jan-Feb;29(1):23-32.

33. Bryan L. Burke, James M. Robbins, TM Bird, Charlotte A. Hobbs, Claire Nesmith, **John M. Tilford.** "Trends in Hospitalizations for Neonatal Jaundice and Kernicterus in the United States: 1988 to 2005." *Pediatrics,* 2009; Feb;123(2):524-32.

34. Stephen M. Bowman, Tommy M. Bird, Mary E. Aitken, **John M. Tilford.** "Trends in Hospitalizations Associated with Pediatric Traumatic Brain Injuries." *Pediatrics*, 2008 Nov;122(5):988-93

35. Laura Smith-Olinde, Scott D. Grosse, Frank Olinde, Patti F. Martin, **John M. Tilford.** "Health State Preference Scores for Children with Permanent Childhood Hearing Loss: A Comparative Analysis of the QWB and HUI3." *Quality of Life Research.* 2008 Aug;17(6):943-53.

36. **John M. Tilford**, Allen C. Goodman, Mary E. Aitken, P. David Adelson. "Measuring the Cost-effectiveness of Technologic Change in the Treatment of Pediatric Traumatic Brain Injury." *The Journal of Trauma.* 2007 Dec;63(6 Suppl):S113-20; discussion S121.

37. Mario A. Cleves, Charlotte A. Hobbs, Phillip A. Cleves, **John M. Tilford**, TM Bird, James M. Robbins. "Congenital Defects Among Liveborn Infants with Down Syndrome. *Birth Defects Res.A Clin.Mol.Teratol.* 2007 Aug;79: 657-63.

38. **John M. Tilford**, Mary E. Aitken, Allen C. Goodman, Debra H. Fiser, Jeffrey B. Killingsworth, Jerril W. Green, P. David Adelson. "Child Health Related Quality of Life Following Neurocritical Care for Traumatic Brain Injury: An Analysis of Preference-Weighted Outcomes." *Neurocritical Care*, Neurocrit Care. 2007 Aug;7(1):64-75.

39. James M. Robbins, T.M. Bird, **John M. Tilford**, Mario A. Cleves, Charlotte A. Hobbs, Scott D. Grosse, Adolpho Correa, A. "Hospital Stays, Hospital Charges, and In-Hospital Deaths Among Infants with Selected Birth Defects - United States, 2003." *Journal of American Medicine Association.* 2007 Feb;297(8):802-803

40. T.M. Bird, Charlotte A. Hobbs, Mario A. Cleves, **John M. Tilford**, James M. Robbins. "National Rates of Birth Defects Among Hospitalized Newborns," *Birth Defects Research Part A Clinical and Molecular Teratology,* 2006 Nov;76(11):762-9.

41. James M. Robbins, T.M. Bird, **John M. Tilford**, J. Alex Reading, Mario A. Cleves, Mary E. Aitken, Charlotte M. Druschel, Charlotte A. Hobbs. "Reduction in newborns with discharge coding of *in utero* alcohol effects in the United States, 1993 to 2002," *Archives of Pediatric and Adolescent Medicine, 2006 Dec; 160:1224-1231.*

42. Stephen J. Pont, James M. Robbins, T. M. Bird, James B. Gibson, Mario A. Cleves, **John M. Tilford**, Mary E. Aitken. "Congenital Malformations Among Liveborn Infants with Trisomies 18 and 13." *American Journal of Medical Genetics*, 2006 Aug 15;140(16):1749-56.

43. James M. Robbins, **John M. Tilford**, T. M. Bird, Mario A. Cleves, J. Alex Reading, Charlotte A. Hobbs. "Hospitalizations of newborns with folate-sensitive birth defects before and after fortification of foods with folic acid." *Pediatrics*, 2006 Dec;118(6):2608.

44. Folafoluwa O. Odetola, **John M. Tilford**, Matthew M. Davis. "Variation in the Use of Intracranial Pressure Monitoring and Mortality in Critically Ill Children with Meningitis in the United States." *Pediatrics*, 2006 Jun;117(6):1893-900.

45. Adriana M. Lopez, **John M. Tilford**, K.S. Anand, Chan-Hee Jo, Jerril W. Green, Mary E. Aitken, Debra H. Fiser. "Variation in Pediatric Intensive Care Therapies and Outcomes by Race, Gender, and Insurance Status." *Pediatric Critical Care Medicine,* 2006 Jan;7(1):2-6.

46. Zola K. Moon, Frank L Farmer, **John M. Tilford**. "Attenuation of Racial Differences in Health Services Utilization Patterns for Previously Uninsured Children in the Delta." *The Journal of Rural Health*, 2005 Fall;21(4):288-94.

47. **John M. Tilford,** Mary E. Aitken, KJS Anand, Jerril Green, Allen C. Goodman, James Parker, Jeff Killingsworth, Debra Fiser, and David Adelson. "Hospitalizations for Critically Ill Children with Traumatic Brain Injuries: A Longitudinal Analysis." *Critical Care Medicine*, 2005 Sep;33(9):2074-81.

48. **John M. Tilford**, Scott D. Grosse, James M. Robbins, Jeffrey M. Pyne, Mario A. Cleves, and Charlotte A. Hobbs. "Health State Preference Scores of Children with Spina Bifida and Their Caregivers." *Quality of Life Research*, 2005 May;14(4):1087-98.

49. Jeff Killingsworth, **John M. Tilford**, James Parker, James Graham, Rhonda Dick, Mary E. Aitken. "National Hospitalization Impact of Pediatric All-Terrain Vehicle Injuries." *Pediatrics,* 2005 Mar;115(3):e316-21.

50. Perla A. Vargas, Pippa M. Simpson, J. Gary Wheeler, Rajiv Goel, Charles R. Field, **John M. Tilford**, Stacie M. Jones. "Characteristics of Children with Asthma in a Head Start Program." *Journal of Allergy and Clinical Immunology,* 2004 Sep;114(3), 499-504.

51. Jeffrey R. Kaiser, **John M. Tilford**, Pippa M. Simpson, Walid A. Salhab, Charles R. Rosenfeld. "Hospital Survival of Very Low Birth Weight Neonates from 1977-2000." *Journal of Perinatology*, 2004 Jun;24(6):343-50.

52. **John M. Tilford**, Mario A. Cleves, and Sadia Ghaffar. "Management of Hypoplastic Left Heart Syndrome," (letter) *Pediatrics,* 2003 Nov;112(5):1210-1; and 2004 Feb;113(2):431-2.

53. Zola K. Moon, Frank L Farmer, **John M. Tilford**, and Kelly J. Kelleher. "Dental Disadvantage among the Disadvantaged: Double Jeopardy for Rural Schoolchildren." *Journal of School Health,* 2003 Aug;73(6):242-4.

54. **John M. Tilford** and James G. Parker. A Gender Bias in the Allocation of ICU Resources? *Critical Care Medicine*, 2003 Jul;31(7):2073-4.

55. James M. Robbins, **John M. Tilford**, Stephen R. Gillaspy, Jennifer L. Shaw, Donald D. Simpson, Richard F. Jacobs, J. Gary Wheeler. "Parental Emotional and Time Costs Predict Compliance with Respiratory Syncytial Virus Prophylaxis" *Ambulatory Pediatrics,* 2002 Nov-Dec;2(6):444-8

56. Mary E. Aitken, **John M. Tilford**, Kathleen W. Barrett, James G. Parker, Pippa Simpson, Jeanne Landgraf, James M. Robbins. "Health Status of Children After Admission for Injury." *Pediatrics,* 2002 Aug;110(2 Pt 1):337-42.

57. **John M. Tilford.** "Cost-Effectiveness Analysis and Emergency Medical Services for Children: Issues and Applications," *Ambulatory Pediatrics,* 2002 Jul-Aug;2(4 Suppl):330-6.

58. **John M. Tilford,** James M. Robbins, Charlotte Hobbs. "Improving Estimates of Caregiver Time Cost and Family Impact Associated with Birth Defects," *Teratology*, 2001;64 Suppl 1:S37-41

59. **John M. Tilford,** Pippa M. Simpson, Timothy S. Yeh, Shelly Lensing, Mary E. Aitken, Jerril W. Green, Judith Harr, and Debra H. Fiser. "Variation in Therapy and Outcome for Pediatric Head Trauma Patients," *Critical Care Medicine*, 2001 May;29(5):1056-61.

    Reviewed in *Pediatric Emergency & Critical Care* and *Intensive Care Monitor*.

60. James M. Robbins, **John M. Tilford**, Richard F. Jacobs, J. Gary Wheeler, Stephen Gillaspy, and Gordon E. Schutze. "Costs and Respiratory Syncytial Virus," (letter) *Pediatrics*, 2001 Mar;107(3):608-9.

61. **John M. Tilford**, Pippa M. Simpson, Jerril W. Green, Shelly Lensing, and Debra H. Fiser. "Volume-Outcome Relationships in Pediatric Intensive Care Units," *Pediatrics*, 2000 Aug;106(2 Pt 1):289-94.

    Reviewed in *Research Briefs*.

62. Mingliang Zhang, John C. Fortney, **John M. Tilford**, and Kathryn M. Rost. "An application of the inverse hyperbolic sine transformation," *Health Services and Outcomes Research Methodology*, 2000 Jun;1(2):165-171.

63. Debra H. Fiser, **John M. Tilford**, and Paula K. Roberson. "Relationship of Illness Severity and Length of Stay to Functional Outcomes in the Pediatric Intensive Care Unit: a Multi-institutional Study," *Critical Care Medicine*, 2000 Apr;28(4):1173-9.

64. Allen C. Goodman, **John M. Tilford**, Janet Hankin, Harold D. Holder, and Eleanor Nishiura, "Alcoholism Treatment Offset Effects: An Insurance Perspective." *Medical Care Research and Review*, 2000 Mar;57(1):51-75.

65. KJS Anand and **John M. Tilford**. "Has the Increased Survival of Premature Infants Affected Resource Utilization in Pediatric Intensive Care Units?" *Critical Care Medicine*, 2000 Mar;28(3):900-2.

66. **John M. Tilford**, Paula K. Roberson, Shelly Lensing, and Debra H. Fiser. "Improvement in Pediatric Critical Care Outcomes," *Critical Care Medicine*, (letter) 2000 Feb;28(2):601-3.

67. **John M. Tilford**, James M. Robbins, Sarah J. Shema, and Frank L Farmer. "Response to Health Insurance by Previously Uninsured Rural Children," *Health Services Research*, 1999 Aug;34(3):761-75.

68. Allen C. Goodman, Miron Stano, and **John M. Tilford** (authorship determined alphabetically). "Household Production of Health Investment: Analysis and Applications," *Southern Economic Journal*, 1999 Apr;65(4): 791-806.

69. **John M. Tilford**, Paula K. Roberson, Shelly Lensing, Debra H. Fiser. "Differences in Pediatric ICU Mortality Risk Over Time." *Critical Care Medicine*, 1998 Oct;26(10):1737-43.

Reviewed in *Critical Care Management, Research Briefs,* and abstracted in *Pediatric News.*

70. James M. Robbins, **John M. Tilford**, Richard F. Jacobs, J. Gary Wheeler, Stephen Gillaspy, and Gordon E. Schutze. "A Number Needed to Treat Analysis of the Use of Respiratory Syncytial Virus Immune Globulin to Prevent Hospitalization.," *Archives of Pediatric and Adolescent Medicine*, 1998 Apr;152(4):358-66.

    Reviewed in *Infectious Diseases in Children.*

71. Camilla M. Romund, Frank L Farmer, and **John M. Tilford**. "U.S. Public School Enrollment-based Health Insurance Initiatives and America's Uninsured," *Journal of School Health.* 1997 Dec;67(10):422-7.

72. **John M. Tilford**, William E. Garner, Steven W. Strode, Ann B. Bynum. "Rural Arkansas Physicians and Telemedicine Technology: Attitudes in Communities Receiving Equipment." *The Telemedicine Journal,* 1997 Winter;3(4):257-63.

73. Allen C. Goodman, Eleanor Nishiura, Janet R. Hankin, Harold D. Holder, and **John M. Tilford**. "Long Term Alcoholism Treatment Costs," *Medical Care Research and Review*, 1996 Dec;53(4):441-64.

74. **John M. Tilford** and Debra H. Fiser. "Futile Care in the Pediatric Intensive Care Unit: Ethical and Economic Considerations," editorial, *Journal of Pediatrics*, 1996 Jun;128(6):725-7.

75. Vaughn I. Rickert, Sandra K. Pope, **John M. Tilford**, Sarah Hudson Scholle, John B. Wayne, and Kelly J. Kelleher. "The Effects of Mental Health Factors on Ambulatory Care Visits by Rural Teens," *Journal of Rural Health*, 1996 Summer;12(3):160-8.

B. Book Chapters

1. **J. Mick Tilford** and Ali Raja. "Is More Aggressive Treatment of Pediatric Traumatic Brain Injury Worth It?" in *Economic Evaluation of Child Health*, Wendy Ungar (ed.), Oxford University Press, 2009.

2. Werner Brouwer, Job Van Exel, and **J. Mick Tilford**. "Incorporating Caregiver and Family Effects in Economic Evaluations of Child Health, in *Economic Evaluation of Child Health*, Wendy Ungar (ed.), Oxford University Press, 2009.

C. Non Peer Reviewed Publications

1. Jason Scheel, **J. Mick Tilford**, and Melanie Boyd. HEDIS Measures: Using Numbers to Improve Health in Arkansas. *Journal of the Arkansas Medical Society.* 2010 Feb;106(8):180-1.

2. **J. Mick Tilford**, Child Health Economics at the IHEA 7th World Congress. *iHEAweek* no. 123, September 2009.

3. **John M. Tilford**, Book Review of *The Cost of Birth Defects: Estimates of the Value of Prevention*, by Norman J. Waitzman, Richard M. Scheffler, Patrick S. Romano. *Journal of Perinatology*, 17(2): 175, 1997.

4. Paula K. Roberson, **John M. Tilford**, and Sarah J. Shema. "Developing Instruction in Research Skills for Pediatric Fellows," *Proceedings of the Statistical Education Section of the American Statistical Association*, 1995.

5. **John M. Tilford**, Paula K. Roberson, and Debra H. Fiser. "Using lfit and lroc to Evaluate the Performance of Mortality Prediction Models," *Stata Technical Bulletin*, 28: 14-18, November 1995. Cited in the Stata® User Manual under Logistic Regression.

D. Submitted Manuscripts

1. Scott D. Grosse, Jamison Pike, Rieza Soelaeman, **J. Mick Tilford**. "Quantifying Family Spillover Effects in Economic Evaluations: Measurement and Valuation of Informal Care Time." Submitted to *Pharmacoeconomics*.

2. Clare Brown, **J. Mick Tilford**, D. Keith Williams, Karen A. Kuhlthau, Jeffrey M. Pyne, Werner BF Brouwer, Nalin Payakachat. "Measuring Caregiver Spillover Effects Associated with Autism Spectrum Disorders: A Comparison of the EQ-5D and SF-6D." Submitted to *Pharmacoeconomics*.

3. Sharla Smith, Glen Mays, **J. Mick Tilford**, T. Mac Bird, et al. "Public Health System Partnerships and The Scope of Maternal and Child Services: A Longitudinal Study." Submitted to *Frontiers in Public Health Services and Systems Research*.

E. Professional Reports

1. "Arkansas Health Care Independence Program (Private Option), Section 1115 Demonstration Waiver Interim Report." Prepared for Arkansas Center for Health Improvement, March 2016.

2. **J. Mick Tilford**, Mir Ali, T. Mac Bird, Stephen Bowman, Jake Coffey, Karen Drummond, Holly Felix, Liz Gates, M. Kathryn Stewart, Melanie Boyd, Kristina Bondurant, Anita Joshi, Pedro Ramos, Nichole Sanders, Mayumi. "Arkansas State Partnership Health Insurance Marketplace: Year One Evaluation." Prepared for Arkansas Insurance Department, June 2015.

3. **J. Mick Tilford**, Chenghui Li, and Sharla Smith. "The Economic Cost of Health Inequalities in Arkansas." Prepared for the Arkansas Minority Health Commission, April 2014.

4. **J. Mick Tilford**, Austin Porter, Jason Scheel, Melanie Boyd, and Michelle Pullman. Hospitalizations and Medical Care Costs of Serious Traumatic Brain Injuries, Spinal Cord

Injuries, and Traumatic Amputations. Submitted to Arkansas Spinal Cord Commission, June 2013.

5. **J. Mick Tilford** and William Watson. "Fiscal and Policy Implications for the State of Arkansas from Rebalancing Long Term Care Services and Supports Following Provisions in the Patient Protection and Affordable Care Act of 2010." Arkansas Department of Health and Human Services, Division on Aging, September 2012.

6. Jennifer Sullivan and Kathleen Stoll. "The Great Divide: When Kids Get Sick, Insurance Matters." Families USA, February 2007. Data Analysis and Technical Appendix by **J. Mick Tilford.**

7. "Evaluation of the Family Planning Demonstration Waiver: A Report to the Division of Medical Services of the Arkansas Department of Human Services," October 2004.

8. Kate Stewart, Ann P. Riley, **John M. Tilford.** "Evaluation of the Family Planning Demonstration Waiver: An Interim Report to the Division of Medical Services of the Arkansas Department of Human Services." April, 2002.

9. **John M. Tilford**. "Expansion of Medicaid Services for Children and Pregnant Women in the State of Arkansas: A Cost Analysis," The Governor's Task Force on Health Care Reform, April 1994.

10. **John M. Tilford**. "Access to Medical Care and the Demand for Medical Care," Executive Summary written for the Agency for Health Care Policy and Research, January 1994.

11. **John M. Tilford**. "Cigarette Smoking Behavior and Potential Health Care Savings in the State of Michigan," Final Report to the Michigan Health Care Education and Research Foundation, May 1993.

F. Unpublished Thesis

"Coinsurance, Willingness to Pay for Time, and Elderly Health Care Demand." Unpublished Ph.D. dissertation. Detroit MI: Wayne State University, 1993. Thesis committee: Allen C. Goodman (chair), Gail Jensen, Steve Spurr, Janet Hankins.

G. Lay Publications

1. **J. Mick Tilford.** Health-care Economics and the Federal Mandate. *Arkansas Democrat Gazette*, November 14, 2010.

2. **J. Mick Tilford.** Missing Markets for Health Insurance. *Arkansas Democrat Gazette*, March 29, 2013.

VII. SCIENTIFIC PRESENTATIONS

A. Invited Presentations and Lectures

1. Arkansas Department of Health Grand Rounds, "What Do Students of Health Care Economics Know About Health Care Reform?" March, 2017

2. Arkansas Department of Health Grand Rounds, "The Economic Cost of Health Inequalities in Arkansas," September, 2014

3. Health Disparities Panel for Delta Leadership Institute, "Health Disparities: Economic Cost and Policy Research," September, 2014.

4. International Health Economics Association (IHEA), European Conference on Health Economics (ECHE), "Nursing Roles and Health Care Economics" Dublin, Ireland, July, 2014.

5. Arkansas Minority Health Summit Panel Discussion with Darrell Gaskin, Brian Smedley, and moderated by T.J. Holmes, April 2014.

6. Arkansas Academy of Audiology, Keynote Address, May 2012.

7. NIMH Research Track on Health Care Reform at the American Psychiatric Association Meetings, "Measuring Quality-Adjusted Life Years in Children with Autism," May 2011.

8. Central Michigan University, Department of Economics, "Challenges and Opportunities in the Economic Evaluation of Child Health Services," April 2010.

9. Cincinnati Children's Hospital Grand Rounds. "Challenges and Opportunities in the Economic Evaluation of Child Health," May 2009.

10. Division of Health Services Research, Cincinnati Children's Hospital. "Methods for Addressing Selection Bias in Observational Studies," May 2009.

11. Michigan Department of Health, Lansing, MI. "Incorporating Family Effects in Economic Evaluations of Child Health Interventions," April 2008.

12. National Study on Cost and Outcomes of Trauma (NSCOT) for Kids, sponsored by the Agency for Healthcare Quality and Research, and the Emergency Medical Services for Children program at the Maternal and Child Health Bureau. "Measuring the Cost-effectiveness of Technological Improvement in the Treatment of Traumatic Brain Injury" March 2007.

13. Agency for Healthcare Research and Quality, 10th Healthcare Cost and Utilization Project (HCUP) Partners Meeting. "HCUP Partner Data Contributing to the Public Good: Injury Impact and Policies," March 2006.

14. Centers for Disease Control and Prevention Conference on Prioritizing a Research Agenda for Orofacial Clefts, Atlanta GA. "Caregiver Time Costs," January 2006.

15. Centers for Disease Control and Prevention, Atlanta GA: "Health Effects of Congenital Hearing Loss," March 2005.

16. National Institutes of Arthritis and Musculoskeletal and Skin Diseases Workshop on the Burden of Muscle Disease, Bethesda Maryland, January 2005.

17. Centers for Disease Control and Prevention – Charting the Course: Birth Defects, Developmental Disabilities, and Disability and Health, Atlanta, Georgia: "Health Utilities and Time Costs for Caregivers of Children with Spina Bifida," September 2002.

18. National Congress on Childhood Emergencies, Dallas, TX: "Economic Evaluation," (with Anne Haddix) April 2002.

19. National EMSC Grantee Meeting, Tysons Corner, VA: "Grant Writing," June 2001.

20. Ambulatory Pediatric Association Conference - Improving Emergency Medical Services for Children through Outcomes Research: An Interdisciplinary Approach, Reston Virginia, "Measuring Cost and Cost-effectiveness," March 2001.

21. National Congress on Childhood Emergencies, Baltimore, Maryland: "Cost-Benefit and Cost-Effectiveness Analysis," (with Anne Haddix) March 2000.

22. St. Georges Hospital and Medical School, London, United Kingdom: "Measuring the Cost and Quality of Pediatric Intensive Care Units," June 1999.

23. Aitken Neuroscience Center, New York, NY. "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients," November 1998.

B. Peer-Reviewed Research Presentations (selected)

1. **Tilford JM**, Melanie Boyd, Kristine Bondurant, Holly Felix, Pedro Ramos, Liz Gates, Mir Ali, Stephen Bowman. Comparison of Private Insurance Consumers in Arkansas: Medicaid and Exchange Enrollees. AcademyHealth Annual Research Meeting. June 2016.
2. **Tilford JM.** Ideas for improving health economics content in student term papers. American Society of Health Economist ASHEcon. June 2016.
3. **Tilford JM**, Payakachat N, Kovacs E, Pyne J, Kuhlthau K. Outcomes associated with gastrointestinal disorders for children with autism spectrum disorders and their caregivers. Presented as an organized session with Eve Wittenberg and Lisa Prosser. IHEA/ECHE, July 2014.
4. **Tilford JM**, Payakachat N, Kuhlthau K, Pyne JM, Kovacs E, Brouwer W. Health utilities and caregiver spillover effects associated with sleep problems in children with autism

spectrum disorders. The International Society for Quality of Life Research (ISOQOL) 20th Annual Meeting, Miami, FL, October 2013.

5. Payakachat N, Hoefman RJ, Kovacs, van Exel J, Pyne J, Kuhlthau K, **Tilford JM**, Brouwer W. Quality of life among parents of children with autism spectrum disorders: A comparison of generic instruments. The International Society for Quality of Life Research (ISOQOL) 19th Annual Meeting. Budapest, Hungary, October 24-27, 2012. (Platform)
6. **Tilford JM**, Payakachat N, Pyne JM, Kuhlthau KA, Comparing experienced utility values from generic instruments for caregivers of children with autism. American Society of Health Economists, Minneapolis MN, June 2012.
7. **Tilford JM**, Payakachat N, Pyne JM, Kuhlthau KA, Brouwer WB. Comparing experienced utility values from generic instruments for caregivers of children with autism. European Conference on Health Economics, Zurich Switzerland, July 2012.
8. Payakachat N, **Tilford JM**, Pyne J, Bellando J, Kovacs E, Kuhlthau K. Measuring preference-weighted scores for children with autism spectrum disorders: a comparison of generic instruments. The 8th World Congress on Health Economics: Transforming Health & Economics. Toronto, Canada, July 10-13, 2011 (Platform)
9. **Tilford JM**, Pyne JM, Payakachat N, Bellando BJ, Kuhlthau K. "Measuring quality-adjusted life years for economic evaluations of treatments services for children with autism." 15th NIMH Biennial Research Conference on the Economics of Mental Health: Comparative Effectiveness and Mental Health Care Financing, Washington DC, September 2010.
10. **Tilford JM**, Payakachat N. The CarerQol instrument in relation to measures of health utilities and quality of life outcomes in caregivers of children with craniofacial birth defects. 8th European Conference on Health Economics, Helsinki Finland, 2010.
11. **Tilford JM**, Payakachat N, Grosse SD. Comparison of health utility and quality of life measures in family caregivers of children with craniofacial birth defects and autism. American Society of Health Economists, Ithaca NY, 2010.
12. Payakachat N, Grosse SD, **Tilford JM**. Comparison of health utility and quality of life measures in family caregivers of children with craniofacial birth defects. Presented at International Society of Quality of Life meeting in New Orleans, LA, 2009.
13. **Tilford JM**, Raja AI. Is more aggressive treatment of pediatric traumatic brain injury worth it? Presented at International Health Economics Meetings in Beijing China, July 2009.
14. Goodman AC, **Tilford JM**. Sleep Matters! Insights from caregivers of children with disabilities. Presented at the meeting of the American Society of Health Economists, Durham NC, 2008.
15. **Tilford JM**, Fussell J, Schulz E, Casey PH. Family impacts of autism: Analyses from the 2005-2006 national survey of children with special health care needs. Society for Pediatric Research, Waikiki HA, 2008.

16. **Tilford JM.** Correlates of caregiver preference scores. Presented at International Health Economics Meetings in Copenhagen Denmark, July 2007.

17. Bird TM, Hobbs CA, Cleves MA, **Tilford JM**, Aitken ME, Robbins JM. Newborn hospitalizations of infants with congenital diaphragmatic hernia in the US, 1993-2003. Presented at Society for Pediatric Research meetings, Toronto, CA, May 2007.

18. Mendiratta P, **Tilford JM**, Wei J. National trends in percutaneous endoscopic gastrostomy tube placement among hospitalized elderly patients in the United States, American Geriatric Society Annual Meeting, Seattle WA, May 2007.

19. Bird TM, Hobbs CA, Cleves MA, **Tilford JM**, Aitken ME, Robbins JM. Newborn hospitalizations of infants with congenital diaphragmatic hernia in the US, 1993-2003. Presented at National Birth Defects Prevention Network meetings, San Antonio, TX, January 2007.

20. Grosse SD, Smith-Olinde L, **Tilford JM**. Valuing the Health of Children with Congenital Hearing Loss: New Findings from the Arkansas Children's Hospital. DHDD Seminar, October 13, 2006.

21. Powerful Data, Meaningful Answers – The HCUP Kids' Inpatient Database (KID) and the Nationwide Inpatient Sample (NIS). Session panel (with Anne Elixhauser and Pamela Owens from AHRQ) at the Child Health Services Research Interest Group Meeting of AcademyHealth, Seattle Washington, June 2006

22. **Tilford JM**, Goodman AC, Adelson PD. Is More Aggressive Treatment of Pediatric Traumatic Brain Injury Worth It? American Society of Health Economists, Madison Wisconsin, June 2006.

23. Mendiratta P, **Tilford JM**, Wei J. Trends In Hospital Discharge Disposition For Elderly Patients With Infective Endocarditis, American Geriatric Society Annual Meeting, Chicago IL, May 2006.

24. Cleves MA, Hobbs CA, Cleves PA, **Tilford JM**, Bird TM, Robbins JM. Major birth defects among live born infants with Down syndrome in the United States: 1993 through 2002. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

25. Bird TM, **Tilford JM**, Cleves MA, Hobbs CA, Robbins JM. National birth defect surveillance rates: Administrative data from the Healthcare Cost and Utilization Project compared to select state surveillance systems. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

26. Robbins JM, Bird TM, **Tilford JM**, Cleves MA, Hobbs CA. Length of newborn hospital stay, hospital charges and in-hospital deaths among infants with major birth defects in the United States. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

27. **Tilford JM**, Grosse SD, Robbins JM, Hobbs CA. How does spina bifida affect parental caregivers? Findings for a survey of families in Arkansas. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

28. Robbins JM, Bird TM, **Tilford JM**, Reading AJ, Cleves MA, Aitken ME, Druschel CM, Hobbs CA. Reduction in newborns diagnosed with fetal alcohol exposure in the Unites States, 1993 to 2002. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

29. Smith-Olinde L, **Tilford JM**, Grosse S, Martin PF, Olinde FL. Comparing preference scores of children with congenital hearing loss. *The Bulletin of the American Auditory Society*, 30, 46, 2005.

30. Smith-Olinde L, **Tilford JM**, Grosse SD, Martin PF, Olinde FL. Comparing preference scores of children with congenital hearing loss. Research Poster, *Annual Meeting, American Auditory Society*, Scottsdale, AZ, 2005.

31. **Tilford JM**, Grosse SD, Martin P, Smith-Olinde L. "Health State Preference Scores of Children with Congenital Hearing Loss and Their Caregivers," International Health Economics Association, Barcelona, Spain, July 2005.

32. Robbins JM, Bird TM, **Tilford JM**, Hobbs CA. Can hospital discharge data complement birth defects surveillance? Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

33. Robbins JM, Bird TM, **Tilford JM**, Reading JA, Cleves MA, Aitken MA, Hobbs CA. Reductions in newborns diagnosed with fetal alcohol syndrome in the United States 1993 to 2002. Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

34. Bannister T, **Tilford JM**. Does Teaching Status Influence Medical Errors and Mortality in Pediatric Injury Hospitalizations? Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

35. Bird TM, **Tilford JM**, Cleves MA, Hobbs CA, Robbins JM. Surveying birth defects in states with limited surveillance systems: The value of administrative data. Presented at Southern Society for Pediatric Research meetings, New Orleans, February 2005.

36. Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW, Hobbs CA. "Hospitalizations of Infants with Birth Defects in the United States Before and After Fortification of Grains with Folic Acid." National Congress on Birth Defects and Developmental Disabilities (CDC), Washington DC, July 2004.

37. Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW, Hobbs CA. Newborn hospitalizations for birth defects in the pre and post folic acid fortification periods. Presented at Academy Health meetings, San Diego, June 2004.

Selected as most outstanding paper in child health

38. **Tilford JM**, Aitken ME, Goodman AC, Green JW, Killingsworth JB, Fiser DH. "Pediatric Hospitalizations for Traumatic Brain Injuries: 1997 and 2000." AcademyHealth, San Diego, CA, June 2004.

39. Odetola FO, **Tilford JM**, Davis MM: Utilization of Intracranial Pressure Monitors in Critically Ill Children with Meningitis. AcademyHealth Annual Meeting, June 2004.

40. Odetola FO, **Tilford JM**, Davis MM: Utilization of Intracranial Pressure Monitors in Critically Ill Children with Meningitis. Pediatric Academic Societies' Annual Meeting, May 2004.

41. Hobbs CA, Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW. Have newborn hospitalizations for birth defects declined following fortification of foods with folic acid? Presented at Society for Pediatric Research meetings, San Francisco, May 2004.

42. Thompson JW, **Tilford JM**, Elixhauser AE. "Using the Kid's Inpatient Database," Society for Pediatric Research, Seattle WA, May 2003.

43. Green JW, Robbins JM, Shaw JL, Simpson DD, **Tilford JM**. The effect of hospitalization on the families of otherwise healthy infants with bronchiolitis. Presented at Society for Pediatric Research meetings, Seattle, May 2003.

44. **Tilford JM**, Killingsworth JB, Green JW, Aitken ME. Analysis of pediatric traumatic brain injury over time: Incidence, therapies, and outcome. Southern Society for Pediatric Research, New Orleans, LA, February 22, 2003. *Journal of Investigative Medicine* 2003. 51: Supplement 1; S307.

45. **Tilford JM**. "Children with Spina Bifida: Health Utilities and Caregiver Time Cost." APHA130th Annual Meeting & Exposition, Philadelphia, PA, November 2002.

46. **Tilford JM**, Robbins JM, Grosse SD. "Health Utility Relationships for Caregivers of Children with Spina Bifida." International Society for Quality of Life Research, Orlando FL, November 2002.

47. Killingsworth JB, **Tilford JM.** "Are Outcomes Improving for Pediatric Patients with Severe Traumatic Brain Injury?" National Congress on Childhood Emergencies, Dallas TX, April 2002.

48. **Tilford JM**, Farmer FL, Kelleher KJ, Robbins JM. "Fluoridation and Children's Demand for Dental Care: Analysis of Two Rural Communities." International Health Economics Association, York UK, July 2001.

49. **Tilford JM**. "Willingness to Pay for a Reduction in Doctor's Office Waiting Time," International Health Economics Association, York UK, July 2001.

50. **Tilford JM**, Farmer FL, Kelleher KJ, Robbins JM. "Fluoridation and Children's Demand for Dental Care: Analysis of Two Rural Communities." Society for Pediatric Research, May 2001.

51. **Tilford JM**, Aitken ME, Simpson PM, Lensing S, Green JW, Fiser DH, "Variation in Pediatric Intensive Care Unit Therapies by Race and Insurance Status," Association for Health Services Research, June 2000.

    Finalist for Best Paper

52. **Tilford JM**, Zhang M. "Modeling Health Care Demand with the Inverse Hyperbolic Sine Transformation," International Health Economics Association Meetings, Rotterdam, The Netherlands, June 1999.

53. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients," Association for Health Services Research, June 1999.

54. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Volume-Outcome Relationships in Pediatric Intensive Care Units," Society for Pediatric Research, May 1999.

55. Robbins JM, **Tilford JM**, Gillaspy SR, Thomas MD, Lensing SY, Wheeler JG. "Emotional and time costs of RSV-IG." Society for Pediatric Research meetings, May, 1999.

56. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Volume-Outcome Relationships in Pediatric Intensive Care Units," Southern Society for Pediatric Research, February 1999.

57. Robbins JM, **Tilford JM,** Gillaspy SR, Thomas MD, Lensing SY, Wheeler JG. "Baby and parental reactions to RSV-IG administration." Southern Society for Pediatric Research meetings, February, 1999.

58. **Tilford JM**, Simpson PM, Lensing S, Harr J, Fiser DH. "Comparison of Resource Utilization and Readmissions in Pediatric Intensive Care: The Impact of a Monitored Care Unit," Association for Health Services Research, June 1998.

59. **Tilford JM**, Simpson PM, Lensing S. Fiser DH. "Differences in Pediatric ICU Risk of Mortality Over Time," Southern Society for Pediatric Research, February 1998.

60. Watson JE, **Tilford JM**, Fiser DH, Casey PH. "Failure-to-Thrive as a Comorbidity in the Pediatric Intensive Care Unit: Prevalence and Resource Use." Southern Society for Pediatric Research Annual Meetings, February 1998.

61. Robbins JM, Wheeler JG, Gillaspy SR, **Tilford JM**, Cheadle MG, Clayton JE. Follow-up of infants treated with respiratory syncytial virus immune globulin. Southern Society for Pediatric Research, February 1998.

62. **Tilford JM**. "Quality and Cost-Containment in Pediatric Intensive Care," Emergency Medical Services for Children National Meeting, January 1997.

63. **Tilford JM**, Robbins JM, Farmer FL. "Utilization and Costs of Vision Benefits by Previously Uninsured School-Aged Children," Southern Society for Pediatric Research, February 1997 meetings.

64. **Tilford JM**, Robbins JM, Marshall JM, Flick EM, Mohrmann H. "Relationship Between Prescribed Medicines, Emergency Department Use, and Inpatient Hospitalizations for Children with Asthma," Southern Society for Pediatric Research, February 1996 meetings.

65. Robbins JM, **Tilford JM**, Sissel PA, Manjanatha S, Farmer FL. "Predictors of Health Care Utilization Among Children in the Mississippi Delta," Southern Society for Pediatric Research Annual Meetings, February 1996.

66. Kellogg KW, Fawcett DF, Scholle SH, Anders M, **Tilford JM**, Robbins JM. "Costs of Delivering Beta-Agonist in a Protocol Driven Respiratory Care Plan for Asthma," Southern Society for Pediatric Research Annual Meetings, February 1996.

67. **Tilford JM**, Roberson PK, Lensing S, Fiser DH. "Cost Containment and Clinical Performance in Pediatric Intensive Care," Association for Health Services Research, Chicago, June 1995 meetings.

68. **Tilford JM**, Robbins JM, Shema SJ, Field C, Farmer FL, Kelleher KJ, Association for Health Services Research, Chicago, June 1995 meetings "Health Care Utilization and Costs of Previously Uninsured Rural Children."

69. Roberson PK, Shema SJ, **Tilford JM**. "Developing Instruction in Research Skills for Pediatric Fellows." American Statistical Association Annual Meeting, August 1995.

70. Rickert VI, Pope SK, **Tilford JM**, Scholle SH, Wayne J, Kelleher KJ. "The Effects of Depression and Problem Drinking on Rural Adolescent Ambulatory Health Care Use." Society for Adolescent Medicine, March 1995.

71. Shema SJ, Robbins JM, **Tilford JM**, Farmer FL, and Kelleher KJ. "Health Status of Uninsured Rural Adolescents." Southern Society for Pediatric Research Annual Meeting, 1995.

72. **Tilford JM**, Robbins JM, Shema SJ, Feild C, Farmer FL, and Kelleher KJ. "Insuring The Uninsured: Health Care Expenditures By Rural Children." Southern Society for Pediatric Research Annual Meetings, 1995.

73. **Tilford JM**. "Coinsurance, Time, and Differential Use of Health Care Among the Medicare Elderly," Association for Health Services Research, San Diego, June 1994 meetings.

74. Fiser DH, Roberson PK, **Tilford JM**, Harshbarger S, and the Pediatric Critical Care Study Group. "Prediction of Functional Outcome in PICU: A Multi-Institutional Study." Society of Critical Care Medicine, Annual Meetings, 1994.

75. **Tilford JM.** "Coinsurance, Willingness to Pay for Time, and Elderly Health Care Demand." American Public Health Association - Health Economics Committee, Washington D.C., October 31, 1994.

76. Fiser DH, Roberson PK, **Tilford JM,** Robbins JM, Pope SK, Kirby RS, Shema SJ. "Severity and Case-Mix Adjusted Outcome: A Measure of One Dimension of Quality in Pediatric Intensive Care? Society for Pediatric Research, 1994.

VIII. TEACHING AND EDUCATIONAL ACTIVITIES

A. Courses Taught

HSRE 9723: Advanced Health Economics II: Supply-side Economics (Role: Sole Instructor). Three credit hours. This doctoral-level course provides an advanced examination of the supply side of health economics, including theory, methods, and policy implications. The course covers theory and methods for modeling the supply of health care, the theory of managed care insurance and various frameworks for understanding the allocation of resources to hospitals and other providers in the health care system. A key goal of this course is for students to obtain a firm understanding of how researchers attempt to model provider behavior and systems of care. UAMS College of Public Health, Fall 2017 (4 students), Fall 2013 (2 students), Fall 2010 (4 students).

HSRE 9723: Advanced Health Economics I: Demand-side Economics (Role: Sole Instructor). Three credit hours. This doctoral-level course provides an advanced examination of the demand side of health economics, including theory, methods, and policy implications. The course covers theory and methods for modeling the demand for health and health care, the theory of health insurance and various frameworks for incorporating health insurance coverage into models of health care demand, and empirical studies that explicitly account for health, health care, and health insurance in determining labor supply. A key goal of this course is for students to obtain a firm understanding of how researchers attempt to capture the economic aspects of consumer health behavior when studying the impact of health policies and systems of care. UAMS College of Public Health,), Fall 2016 (4 students), Fall 2012 (1 student), Fall 2011 (1 student),), Fall 2009 (2 students).

HSRE 9203: Variation in Health System Performance (Role: Primary Instructor). Three credit hours. At its core, the field of health services research is devoted to the study of variation in health system performance and health care practice. As the second semester in the two-semester sequence, this doctoral-level seminar will focus on what can be learned from studies of variation in health systems and services – investigating the causes, consequences, and solutions to harmful, wasteful, and inequitable variation. In doing so, this course will review conceptual foundations of health services and systems research (HSR), and examine current topics and ongoing research in this field. Students will examine current empirical research conducted by investigators concerning the development, organization, financing, and delivery of health services and their impact on population health. Students will also gain experience in conceptualizing research questions of interest in HSR, developing theoretical frameworks to inform these questions, and critically reviewing the

empirical literature on topics of interest. UAMS College of Public Health, Spring 2017 (4 students), Spring 2016 (4 students), Spring 2015 (4 students), Spring 2013 (2 students).

HSAD 5273: Introduction to Health Economics (Role: Sole Instructor). Three credit hours. Economics is the study of the allocation of scarce resources. Health economics considers the allocation of health care resources to evaluate whether more efficient or equitable distributions can be achieved. The course is a survey of economic issues on significant topics in the health care field. Some topics could stand as a single course. The first class sessions reintroduce economics principles; the subsequent sessions expand on these principles and apply them to health care. UAMS College of Public Health, Spring 2017 (21 students), Spring 2016 (28 students), Spring 2015 (32 students), Spring 2014 (29 students), Spring 2013 (21 students), Spring 2012 (11 students), Fall 2011 (directed study with 3 students), Spring 2011 (20 students), Spring 2010 (19 students), Summer 2008 (2 students), Spring 2007 (16 students), UALR Spring 2003 (14 students), UALR Spring 2002 (16 students), UAMS Division of Biometry Spring 2001 (7 students), UAMS Division of Biometry Spring 1999 (4 students).

Research Skills Course: Developing Grant and Journal Submissions. (Role: Course Director in 1996 and 1997; Course Coordinator in 1994). Non-credit course. This course provided instruction in research designs, introductory statistics, and research skills necessary for preparing research projects from abstract submissions to grant applications. Intended audiences were fellows and junior faculty in the Department of Pediatrics. Fall 1997 (14 students; 23 CME credit hours), Fall 1996 (11 students; 20 CME credit hours). Fall 1994 (15 students; 36 CME credit hours).

Principles of Economics. (Role: Course Director). Three credit hours. This course provides an introduction to principles of micro or macroeconomics. The course is intended for freshman college students and provides a basic understanding of supply and demand for goods and services, market structures, and the role of prices. Wayne State University (1987-1991 with approximately 30 students), Central Michigan University (1984-1985 with approximately 35 students), University of Minnesota – Duluth (1985-1986 with approximately 200 students).

Introductory Statistics. (Role: Course Director). Three credit hours. This course provides business students with an introduction to statistics including basic descriptive statistics, hypothesis testing, and linear regression. University of Minnesota – Duluth (1985-1986 with approximately 20 students), Jackson Community College (1982-1983 with approximately 15 students).

B. Teaching Lectures in University Setting

1. College of Nursing UAMS, Leadership in Healthcare Systems Class "Finance and Health Economics" September 19, 2014. November 6, 2015. July 21, 2016.

2. Cancer Institute Grand Rounds, UAMS. "The revolution in comparative effectiveness research." With Brad Martin, February 27, 2013.

3. College of Public Health UAMS, "Measuring quality-adjusted life years in children with autism." January 11, 2013.

4. College of Public Health UAMS, "The revolution in comparative effectiveness and patient-centered outcomes research: A framework for assessing interventions for children with autism." March 6, 2012.

5. Division of Health Services Research, Department of Psychiatry UAMS. "Measuring quality-adjusted life years in children with autism." December 6, 2010. (With N. Payakachat).

6. College of Public Health UAMS. "Can cost-effectiveness analysis inform financing decisions associated with treatment for autism?" November 2, 2010. (With N. Payakachat)

7. Leadership Education in Neurodevelopmental and Related Disabilities, "Economic Evaluation of Child Health Services for Children with Neurodevelopmental Disabilities." UAMS, April 23, 2010.

8. Health Policy and Promotion Conference, College of Public Health, "Challenges in the Economic Evaluation of Child Health Services," January 16, 2008

9. Health Policy and Promotion Conference, College of Public Health (with P. Mendiratta), "Trends in Hospital Discharge Decisions for Elderly Patients Hospitalized with Infective Endocarditis," January 30, 2007.

10. Health Policy and Promotion Conference, College of Public Health, "Is More Aggressive Treatment of Traumatic Brain Injury in Children Worth It?" July 25, 2006.

11. Jones Eye Institute Grand Rounds, "Introduction to Health Economics," April 13, 2006.

12. Pediatric Faculty Development Seminar, "Using Reference Manager for Your Publications." February 21, 2006.

13. College of Medicine Dean's Research Forum, "Measuring the Return on Investment from Medical Research," October 25, 2005.

14. Pediatric Critical Care Medicine Seminar, "Impact of ICP Monitoring on Outcome in Critically Ill Children with Meningitis: An Application of the Propensity Score Method to Reduce Bias in Observational Studies," October 7, 2005.

15. College of Medicine, UAMS, Introduction to Clinical Medicine I Course, *Health Care Finance*, August 31, 2005.

16. College of Nursing Research Seminar, "Health State Preference Scores of Children with Spina Bifida and Their Caregivers," April 6, 2004.

17. Arkansas Center for Health Improvement: Health Policy Forum, "Developing the Basis for Universal Health Insurance for Children." June 4, 2002.

18. Department of Pediatrics Grand Rounds, "Universal Health Insurance for Children," January 22, 2002.

19. Center for Outcomes Research and Effectiveness, UAMS, "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients," September 22, 1999.

20. College of Nursing - Nurse Theory Course, UAMS, "Introduction to Health Economics," March 19, 1999.

21. Arkansas Children's Hospital - Nursing Grand Rounds, "Hospital Cost and Quality," March 9, 1999.

22. Center for Outcomes Research and Effectiveness, UAMS, "Risk Adjustment Systems in Pediatrics: Methods and Applications," May 27, 1998.

23. Statistical Journal Club, UAMS, "A Note on Alternative Models of the Demand for Health Care," March 10, 1998.

24. Department of Pediatrics Evidence-Based Medicine Lecture Series, "Economic Evaluation of Health Services," December 4, 1997.

25. UALR Master's Program in Health Administration, "Health Care Reform," April 29, 1997.

26. Center for Outcomes Research and Effectiveness (CORE) Scholar Lecture, "Severity Adjustment," January 30, 1997

27. Seventh Annual Professional Development Day – UAMS, "A Primer on Illness Severity, Health Care Costs, and Quality of Care," Little Rock, October 21, 1997.

28. Department of Pediatrics Research Conference, "A Primer on Illness Severity, Resource Use, and Quality of Care," December 5, 1996.

29. Center for Outcomes Research and Effectiveness, UAMS, "Cost Containment and Clinical Performance in Pediatric Intensive Care," March 8, 1995.

30. UALR Master's Program in Health Administration, "Health Services Research," April 5, 1995.

31. Department of Pediatrics Grand Rounds, "Hospital Care: Time to Consider both Cost and Quality," November 8, 1994.

C. Teaching Lectures in a Community Setting

1. Arkansas Primary Care Association Annual Meeting, "Healthcare Economics and the Accountable Care Act," September 2016.

2. Adventures in Learning, "It's the Economy Stupid," Little Rock, April 6th – May 25th, 2005.

3. St. Vincent Health System, Focus Group Participant for Community, November 2004.

4. Case Management Society of America, "A Primer on Cost and Outcomes Measurement," Little Rock, September 1997.

5. Americorps National Service Orientation, "Problems and Prospects for Rural Health Care Services," Little Rock, May 22, 1995.

6. Arkansas School for Mathematics and Science, Panel Discussant, Little Rock, March 16, 1995.

D. Clinical Scientist Mentoring

2006 – 2008: Bryan Burke, M.D.
2006 – 2008: Laura Smith-Olinde, Ph.D.
2004 – 2005: Fola Odetola, M.D.
1998 – 2004: Jeff Kaiser, M.D.
1996 – 1997: Al Torres, M.D.

E. Fellow Advising

2011 - 2013 : Barbara Saunders, M.D.
2006 – 2008: Priya Mendiratta, M.D.
2004 – 2007: Tom Bannister, M.D.
2003 – 2004: Adrianna Lopez, M.D.

F. Dissertation Committee

2018 – Adrienne Nevola (Chair)
2017 – Clare Brown (Chair)
2015 – Mir Ali (Chair)
2015 – 2018: Leah Richardson
2015 – 2017: Rebecca Pope (Chair)
2014 – 2017: Marcia Byers
2014 – 2015: Teresa Hudson
2013 – 2016: Patty Smith
2012 – 2013: Michael Preston (Chair)
2012 – 2013: Sharla Smith (Chair)

2011 – 2013: Diane Robinson (Chair)
2009 – 2011: Mac Bird
2005 – 2007: Angela Green, RN

G. MS/MPH Advising

2018 – Dimple Shah
2017 – Josh Salil
2017 – 2018 Jennifer Morales
2017 – 2018 Jennifer Victory
2016 – 2017 Savannah Skaggs
2016 – 2017 Kristen Alexander
2015 – 2016 John Ukadike
2014 – 2015 Clare Brown
2014 – 2015 Alexandria Beebe
2014 – 2015 Aaron Carroll
2012 – 2013 Pratik Doshi
2012 – 2013 Sabha Talibi
2012 – 2013 Julia Kettlewell
2012 – 2013 Cody Haedon
2010 – 2011 April Moore, MPH
2002 – 2004 Jeff Killingsworth, MPH

H. Mentoring Committee (Chair)

2006 – 2009: Nahed El-Hassan, M.D., MPH

I. Summer Science Student Mentoring

2006: Tammy E. Binz
2017: James Abraham

J. Junior Faculty Mentoring

2015 – Taren Swindle
2013 – Sharla Smith, PhD
2012 – Anthony Goudie, PhD (KL2 Scholar Primary Mentor)
2009 – Qayyim Said, PhD
2009 – Nalin Payakachat, PhD

IX. SERVICE ACTIVITIES

A. University Service Activities

Intercollegiate Faculty Council, University of Arkansas Medical Sciences Faculty Center, 2016-2017.

Panel member, University of Arkansas Medical Sciences, Office of Grants & Scientific Publications, presentation on experiences and responding to questions about the NIH peer-review process, "Fund My Grant! Learn How to Make It Happen from a Panel of Expert Reviewers," April, 2015.

Legislative Testimony, Arkansas State Public Health and Welfare Legislative Committee, Testified on a report commissioned by the Arkansas Minority Health Commission, The Economic Cost of Health Inequalities in Arkansas, September, 2014.

Dean's Executive Committee, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences, 2013 – present. The DEC is the governing body of the COPH.

Graduate Council, University of Arkansas for Medical Sciences (2012 – 2014). The Graduate Council is the governing body of the UAMS Graduate School.

Arkansas Consortium for Health Services Research Executive Committee. University of Arkansas for Medical Sciences (2006-2008). The executive committee provides advice on data infrastructure for conducting health services research.

PhD Admissions Committee for Health Systems Research, College of Public Health, University of Arkansas for Medical Sciences (2006 - 2013). The committee votes on accepting prospective students to the Ph.D. program.

Human Research Advisory Committee. University of Arkansas for Medical Sciences (2000 – 2004). Served as a reviewer and participated in the development of standard operating procedures.

Strategic Plan Committee for Pediatric Administration, Department of Pediatrics, University of Arkansas for Medical Sciences (2000 – 2001). Assisted with the creation of white papers for planning administrative services.

Research Council. Arkansas Children's Hospital Research Institute (1998 1999). Research investigators reviewed policies and procedures associated with the Research Institute.

Governor's Health Care Reform Task Force, State of Arkansas (1993 – 1994). Developed a cost analysis for expansion of health insurance to children.

College of Medicine, UAMS, Admissions Interviews, 2007, 2003, 2001, 2000, 1999 (2). Interviewed prospective medical students and filed a report.

B. Professional Service Activities

Ad Hoc Grant Reviewer for **National Institute of Mental Health**, July 2017.

Advisory Board Participant, **Roche Ltd**, October 2016.

Ad Hoc Grant Reviewer for **Netherland Organisation for Scientific Research**, December 2012.

Ad Hoc Grant Reviewer for **Military Operational Medical Research Program (RAD 3),** June 2012.

Symposium Organizer on Economics of Child Health for **International Health Economics Association,** Toronto Canada, July 2011.

Ad Hoc Grant Reviewer for **Agency for Healthcare Research and Quality – Research Centers for Excellence in Clinical Preventive Services,** July, 2011.

Ad Hoc Grant Reviewer for **National Institutes of Health – Healthcare Delivery and Methodologies (HDM) IRG,** October, 2010.

Ad Hoc Grant Reviewer for **National Institutes of Mental Health – Mental Health Services in Specialty Settings (SRSP)** review committee at NIMH, October, 2010.

Invited Participant for NIMH workshop on Informatics for Autism Research: Community-Wide Solutions, August, 2010.

Ad Hoc Grant Reviewer for **Maternal and Child Health Bureau – Health Resources and Services Administration,** 2005, 2004, 2002, 2001 (2), 1999 (2), 1998, 1997.

Ad Hoc Grant Reviewer and Panel Chair for **Maternal and Child Health Bureau – Health Resources and Services Administration,** June 2002.

Member of Poster Award Committee for conference of the **International Health Economics Association,** Beijing China, 2009.

Member of Scientific Committee for conference of the **International Health Economics Association,** 2009, 2011.

Member of Scientific Committee for conference of the **American Society of Health Economists,** 2008

Member of Scientific Committee for inaugural conference of the **American Society of Health Economists,** 2006

Member of Project Steering Committee, **American Academy of Pediatrics.** Evaluation of care of children in the emergency department: Guidelines for preparedness.

Member of Advisory Council for Emergency Medical Services for Children program, **Maternal and Child Health Bureau, Health Resources and Services Administration.** National trauma registry for children project.

Member of Planning Committee for interdisciplinary conference on Emergency Medical Services for Children, **Ambulatory Pediatric Association,** 2000 - 2001

Member of the Research, Evaluation, and Information Systems task force to revise 5-year plans for the **Emergency Medical Services for Children program, Maternal and Child Health Bureau**, June 1999 – 2001

C. Community and Public Service Activities

Member of the Rehabilitation Subcommittee for the **Arkansas Trauma Advisory Council**, 2012.

Member of cost analysis group for Arkansas' Closing the Addiction Treatment Gap project, **Division of Behavioral Health Services, Arkansas Department of Human Services**, 2009.

Senior Analyst for the **Arkansas Foundation for Medical Care** to assist with data mining and program evaluation.

Technical Consultant for Epidemiology Division of the **Arkansas Department of Health** to assist with return on investment calculations associated with reductions in hospitalizations of tobacco related conditions.

Technical Consultant to **Michigan Department of Community Health**, Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology to assist with economic evaluation of caregiver interventions.

D. Services to Academic/Professional Journals and Editorial Boards

Editor: Health Economics Network (HEN) journal: *Economic Evaluation Methods*

Journal Reviewer:

Ambulatory Pediatrics
Applied Health Economics and Health Policy
BMC Health Services Research
Clinical Performance and Quality Health Care
Contemporary Policy
Critical Care Medicine
Frontiers in Public Health Systems and Services Research
Health Affairs
Health and Quality of Life Outcomes
International Journal for Quality in Health Care
JAMA Pediatrics
Journal of Autism and Developmental Disabilities
Journal of General Internal Medicine
Journal of Health Care for the Poor and Underserved
Journal of Pediatrics
Journal of Rural Health
Journal of the Canadian Academy of Child and Adolescent Psychiatry

Medical Care
Medical Decision Making
NEJM
Neurology and Therapy
Obesity
Pediatrics
Pharmacoeconomics
Social Science and Medicine
The Patient
Quality of Life Research
Value in Health

Book Reviewer:

The Economics of Health and Health Care, Sherman Folland, Allen Goodman, and Miron Stano, Prentice-Hall Inc.: Upper Saddle River, NJ, 1997.

Monograph Reviewer:

Congressional Office of Technology Assessment, *Non-Financial Barriers to Access to Health Care*, 1993.

Discussant:

American Public Health Association, Session on Prevention and Long Term Care, November 1997

International Health Economics Association, Session on Teaching, July 2011.

E. Professional Memberships

American Society of Health Economists

International Health Economics Association

AcademyHealth

American Economic Association

International Society for Quality of Life Research

X. AWARDS AND HONORS

2018 Recipient of the Outstanding Faculty Award from the College of Public Health Student Council.

2006 Recipient of Best Project Award from Emergency Medical Services for Children Program for Economic Evaluation of Intensive Care Services for Pediatric Traumatic Brain Injury Patients.

2000 Educator of the Year Award from the Department of Pediatrics, University of Arkansas for Medical Sciences.

1998 Excellence in Medical Education Award from the Department of Pediatrics, University of Arkansas for Medical Sciences.

1997 Excellence in Research Award from Blue Cross Blue Shield of Michigan Foundation for a research paper entitled "Long Term Alcoholism Treatment Costs" co-authored with Allen Goodman and others.

1993 Dissertation Research Award from the Agency for Health Care Policy and Research of the Department of Health and Human Services (DHHS).

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES AND PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Supplementary Affidavit of Nathan Johnson

My name is Nathan Johnson. I submit this supplementary affidavit in support of the captioned matter to provide current information as to the loss of revenue experienced by PPAEO Fayetteville and Little Rock health centers as a result of ADH's current interpretation of § 20-16-1703(d). PPAEO experienced a loss of $2,957.00 between March 23, 2018 and July 10, 2018 from patients who were billed for services provided at their first visit and who did not remit payment. (I have included in my calculations only those patients who received services on or before July 10, 2018 as these patients were sent bills over 30 days ago). The $2,957.00 represents a combined loss of patient revenue from both health centers for these patients. Pursuant to ADH's interpretation of the requirement being challenged in this matter, PPAEO staff collected no payments for services obtained during those patients' first visits.

FURTHER AFFIANT SAYETH NOT

State of Kansas)
County of Johnson)

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 8/17/2022. (Seal or Stamp)

Leanne Mayer
Notary Public

Gmail Search mail

Compose

Inbox 1
Sent
Drafts
Categories
Social
Updates 468
Forums 792
Promotions 496
[Gmail]Trash
Bettina +

Sent from my iPhone

> On Oct 31, 2018, at 12:45 PM, Bettina Brownstein <bettinabrownstein@gmail.com> wrote:
>
> Laura: As you are working on the Findings of Fact and Conclusions of
> Law, I want to draw your attention to Hanks v. Sneed, 235 S.W. 3d 883
> (Ark. 2009), which states that for judicial review, the licensee needs
> to obtain a ruling on each individual issue raised, In addition, the
> court requires a ruling on constitutional issues. Accordingly, I am
> requesting in behalf of Respondents that there be such findings of
> fact and conclusions of law on all issues raised on our appeal, even
> the constitutional ones.
>
> In addition, I had previously requested whether the Board would stay
> it's decision pending our appeal to the court.
>
> If you have any questions, please do not hesitate to contact me.
>
> Cordially,
>
> Bettina Brownstein

BEFORE THE STATE BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA D/B/A PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

STIPULATED FACTS; CONCLUSIONS OF LAW AND ORDER

STATUTORY AUTHORITY

This Order is issued under the authority vested in the Arkansas State Board of Health, and the State Health Officer of Arkansas by Ark. Code Ann. §§ 20-7-101, 20-7-109 et seq.; Ark. Code Ann. § § 20-9-204 and 205, and § 20-9-302; and by the Arkansas Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.

Pursuant to the parties' stipulated procedure in the Notice of Hearing, and in lieu of an in-person hearing before a subcommittee, the Petitioner, Arkansas Department of Health, and the Respondents, Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains, stipulated to the following facts in written briefs, which were presented to and adopted by the Arkansas Board of Health on the 25th day of October, 2018:

STIPULATED FACTS

1. The Petitioner, the Arkansas Department of Health, received a complaint regarding Respondents' three licensed abortion facilities.

2. In January and February, 2018, Petitioner, the Arkansas Department of Health, investigated Respondents Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma.

3. Following an investigation and document review, on March 13, 2018, the Department advised Respondent, Little Rock Family Planning Services, by letter that it found that Respondents were deficient by violating Ark. Code Ann. § 20-16-1703(d). Specifically, Petitioner found that Respondents had been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight (48) hour reflection period, in violation of the law.

4. Following an investigation and document review, on March 23, 2018, the Department advised Respondent, Planned Parenthood's centers in Fayetteville and Little Rock, by letter that it found that Respondents were deficient by violating Ark. Code Ann. § 20-16-1703(d). Specifically, Petitioner found that Respondents had been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight (48) hour reflection period, in violation of the law.

5. From the citations, the Respondents appealed to the Board of Health.

CONCLUSIONS OF LAW

1. Pursuant to the parties' stipulated procedure to provide for a fair hearing by submission of written briefs, the Board reviewed the written briefs submitted by the Department and Respondents, which examined the Department's authority and applicability of Ark. Code Ann. § 20-16-1703(d) to the Respondents' actions. Interpretation of a statute is a question of law.

2. After review and consideration of the agreed facts and questions of law, the Board of Health voted during its October 25, 2018, meeting, and affirmed the Department's deficiency

findings and its interpretation of the law. The Board of Health agreed with the Department's written arguments and affirmed the determination that Respondents' conduct fell within the terms of the statute, Ark. Code Ann. § 20-16-1703(d).

3. To the extent that Respondents raised constitutional claims against enforcement of the state statute, the Department responded that the statute is presumed to be constitutional and enforced the law. While noting that the Board of Health does not have authority to declare unconstitutional a statute that the Department was required to enforce, the Respondents' constitutional claims were reviewed and considered by the Board during the review process.

4. To the extent that Respondents raised a tortious interference with contract claim, by upholding the deficiencies based on the Department's arguments, the Board affirmed the Department's assertion that sovereign immunity would preclude that claim.

ORDER

After due consideration and deliberation, the Board of Health affirmed that the stipulated facts against the Respondents were proven as deficiencies and that the Respondents' actions were in violation of Ark. Code Ann. § 20-16-1703(d). The resulting order concerns the rights of the Respondents and is a final agency action. This Order shall become final unless appealed in accordance with Ark. Code Ann. § 25-15-212 within thirty (30) days after service of the Board's decision.[1]

[1] The procedures for review of the Department's decision under Ark. Code Ann. § 20-9-302 (b) provide for finality fifteen (15) days after the decision is sent by certified mail. See also District Court Rule 9(f)(1) Appeals to Circuit Court-Administrative Appeals (noting that if an applicable statute provides a method for filing an appeal from a final decision of any agency and a method for preparing the record on appeal, then the statutory procedures shall apply). However, due to the nature of these proceedings, it appears that any judicial review procedures under the Administrative Procedure Act would apply.

IT IS SO ORDERED this 8 th day of November, 2018.

Catherine Tapp
President
Arkansas State Board of Health

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:
ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Motion to Compel Order that Complies with Arkansas Law

Respondents, pursuant to the Administrative Procedures Act, Ark. Code Ann. §25-15-201 *et seq.*, submit this motion to compel Petitioner to issue a revised order that complies with this Act and Arkansas law.

1. On November 8, 2018, the Arkansas State Board of Health (the "Board") issued an order in the captioned matter which purports to be a final agency action. Order, p.3.

2. The order recites that it was issued, *inter alia*, under the Arkansas Administrative Procedures Act, A.C.A. §25-15-201 *et. seq.* (the "Act" or the "APA"). However, the order fails to comply with this Act, which requires that "there be findings of fact and conclusions of law separately stated." §25-15-210. The order does not do this. It merely recites that "after consideration of the agreed facts and questions of law, the Board of Health voted . . . and affirmed the Department's deficiency findings and its interpretation of the law. The Board of Health agreed with the Department's written arguments and affirmed the determination that Respondents' conduct fell with the terms of the statute, Ark. Code Ann. § 20-16-1703 (d)."

3. The order is insufficient to permit judicial review of the Board's decision to uphold the deficiency citations that are the basis of the administrative appeal. It does not permit a

reviewing court to address and rule on each of the issues raised by Respondents in their administrative appeal.

4. It is well-established that Arkansas law requires the Board to make specific finding on individual issues raised by a respondent in an administrative appeal, including alleged constitutional issues, before a reviewing court will address them. *See Hanks v. Sneed*, 235 S.W. 3d 883, 890, 366 Ark. 371 (Ark. 2006) (citing *Arkansas Contractors Licensing Bd. v. Pegasus Renovation Co.*, 347 Ark. 320 (2001) (An appellant must obtain a ruling from the Board in order to preserve an argument, even a constitutional one, for an appeal from an administrative proceeding.))

3. Petitioners' initial brief raised the following eight, separate points of appeal:

(1) The statute upon which the citations are based, A.C.A. § 20-16-1703(d), as now interpreted by ADH, ("the Payment Ban"), violates the takings clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 22 of the Arkansas Constitution;

(2) The Payment Ban violates the equal protection clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 18 of the Arkansas Constitution;

(3) The Payment Ban violates the privacy rights of Respondents' patients, as guaranteed by the U.S. and Arkansas Constitutions;

(4) The Payment Ban violates the Contracts Clause of the U.S. Constitution, Art. 1, § 10.

(5) The Payment Ban constitutes tortious interference with contract in violation of Arkansas common law;

(6) ADH exceeded its authority in issuing the deficiency citations absent a regulation or rule prohibiting this conduct, and, under A.C.A. § 20-7-109(c), its interpretation of the law as prohibiting payment for services provided at a patient's first visit until the lapse of 48 hours interferes with the practice of medicine;

(7) Issuance of the deficiency citations was arbitrary and capricious, as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit before the lapse of 48 hours; and

(8) Issuance of the deficiency citations was arbitrary and capricious as PPAEO's practice of gathering credit card information at the first visit and then charging patients for services only after a delay of at least 48 hours complies with A.C.A. § 20-16-1703(d).

4. Petitioner, in its response to Respondents' initial brief, responded separately to all of the non-constitutional bases for the appeal (with the exception of number 6, which it did not respond to at all.) However, the order completely fails to respond to any of these separate bases.

5. Respondents intend to raise all the above-enumerated issues on appeal to the circuit court and, under the APA and Arkansas law, are entitled to an order from Petitioner that permits the reviewing court to address and rule on each of these issues.

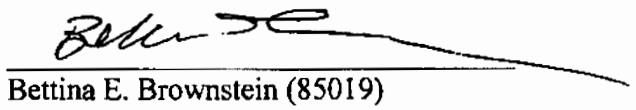
5. Respondents presented facts relevant to each point of appeal via six affidavits. None of these facts were controverted by the Department of Health. Moreover, the department presented no additional facts beyond the five the order characterizes as "Stipulated Facts." However, the order completely ignores the uncontroverted facts presented via Respondents' affidavits.

6. The order labels certain facts "Stipulated Facts." This is incorrect. While Respondents do not contest these facts, they were not stipulated to by Respondents. Moreover, they are incomplete, as there are many additional facts, as contained in the affidavits of Melanie Helsinki, Nathan Johnson, Lori Williams, and Dr. Mick Tilford, that should be considered "stipulated" because they were not disputed by the department. Since they were not controverted by the department, they must be accepted by the Board.

WHEREFORE, Respondents request that this motion be granted and that Petitioner issue a revised order with separately stated conclusions of law and findings of fact that support each conclusion on all eight points of appeal, including the constitutional issues, raised by Respondents in their appeal.

In addition, Respondents renew their request that the deficiency citations contained in the Statements of Deficiencies issued to Respondents be dismissed and that their Motion to Dismiss be granted.*

Respectfully submitted:



Bettina E. Brownstein (85019)
Bettina E. Brownstein Law Firm
904 W. Second St., Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com

*Respondents are in receipt of notices from Petitioner that it deemed affidavits submitted by Respondents in their administrative appeals to be Plans of Correction of the alleged deficiencies contained in the Statements of Deficiencies that are the subject of their appeal. Respondents do not consider these unilateral actions by Petitioner to constitute any type of agreement by them as to the validity of the defiency citations at issue nor as any type of waiver of Respondents' challenges to the legality of the citations.

BEFORE THE STATE BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH **PETITIONER**

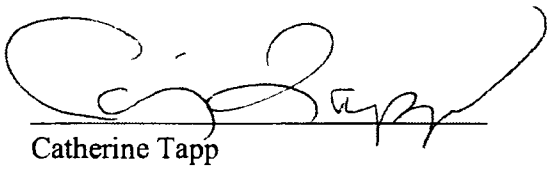
V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA D/B/A PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

ORDER

On October, 25, 2018, after review and consideration of the complete record of undisputed facts, questions of law, and legal arguments submitted by the parties, the Board of Health affirmed the Department's deficiency findings and its interpretation of a statute, specifically, Ark. Code Ann. § 20-16-1703(d). In consideration of the Respondents' November 14, 2018, motion to compel order that complies with Arkansas law, the original order, dated November 8, 2018, is sufficient. Therefore, the motion is denied.

IT IS SO ORDERED this 3rd day of December, 2018.



Catherine Tapp
President
Arkansas State Board of Health

Bettina E. Brownstein
904 W. Second St
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com
December 14, 2018

Re: LRFPS et al v. Arkansas Board of Health et al. 60cv-18-8090

Hon. Timothy Fox
Pulaski Circuit Court, Sixth Div.
401 W. Markham St., Room 210
Little Rock, AR 72201

Dear Judge Fox:

I represent Plaintiffs/Petitioners in the referenced case. On December 13, 2018, I filled a Petition for Writ of Mandamus in their behalf against Defendant/Respondent the Arkansas Board of Health and Respondents, members of the Board of Health. The petition has been served on all Respondents. The Arkansas Attorney General has been notified and will represent the Board of Health in this matter. I write to request a hearing on the petition at the Court's earliest convenience.

By copy of this letter, I am informing opposing counsel of this request.

Thank you for your attention to this matter.

Cordially,

Bettina E. Brownstein

cc: Michael Cantwell, Assistant Attorney General
Vincent Wagner, Assistant Attorney General

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — **PETITIONER**

v. **60CV-18-8090**

ARKANSAS BOARD OF HEALTH — **RESPONDENTS**

ADMINISTRATIVE RECORD

CERTIFICATION OF RECORD OF ADMINSTRATIVE PROCEEDING

I, Jessica Upchurch, certify that the attached record is to the best of my knowledge and belief, a complete record of the procedural history, testimony, and the other matters and things concerning the matter of Arkansas Department of Health v. Little Rock Family Planning Services and Planned Parenthood of Arkansas, and Eastern Oklahoma D/B/A Planned Parenthood Great Plains, Case No. 60CV-18-8090.

I personally prepared the attached record and attest that, to the best of my knowledge; it is the entire record on file with the Arkansas Department of Health.

Jessica Upchurch
Arkansas Department of Health
Office of Medicaid Provider Appeals
4815 West Markham Street, Slot 31
Little Rock, AR 72205
(501) 280-4034

STATE OF ARKANSAS

COUNTY OF PULASKI

Subscribed and sworn before me this 14 day of December, 2018.

Sheneka Robinson

Notary Public

My Commission Expires:
August 1, 2028

SHENEKA ROBINSON
MY COMMISSION # 12705263
EXPIRES: August 1, 2028
Pulaski County

ARKANSAS STATE BOARD OF HEALTH

QUARTERLY MEETING

THURSDAY, October 25, 2018

10:00 A.M.

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

MEMORANDUM

TO: BOARD OF HEALTH MEMBERS

FROM: Jessica Upchurch

DATE: October 15, 2018

RE: October 25, 2018 - Quarterly Meeting

The quarterly meeting of the Arkansas State Board of Health will be held on Thursday, October 25, 2018, at 10:00 a.m., at the Freeway Medical Building, Suite 906 in Little Rock. Please find attached the agenda, meeting minutes from the July 26, 2018 Quarterly Meeting, and related materials for the Board meeting.

If you prefer to conference in, the number is 1-866-434-5269, access code 7207010.

If you have any questions, please feel free to call me at (501) 661-2878. Thank you.

cc: Dr. Nathaniel Smith, Director and State Health Officer
Stephanie Williams, Deputy Director, Public Health Programs
Ann Purvis, Deputy Director for Administration
Dr. Namvar Zohoori, Chief Science Officer
Dr. Gary Wheeler, Chief Medical Officer
Robert Brech, General Counsel
Dr. Glen Baker, Director, Public Health Laboratory
Shirley Louie, Director, Center for Public Health Practice
Patricia Scott, Director, Center for Health Advancement
Renee Mallory, Director, Center for Health Protection
Don Adams, Director, Center for Local Public Health
Dr. Dirk Haselow, Arkansas State Epidemiologist
Dr. Marisha DiCarlo, Director, Health Communications
Michelle R. Smith, Director, Office of Minority Health & Health Disparities
Haley Ortiz, Director, ADH Governmental Affairs Policy
Legal Services
Governor's Office
Legislative Council

QUARTERLY MEETING
STATE BOARD OF HEALTH

AGENDA
October 25, 2018
10:00 a.m.

I. Call to Order / Introduction

II. Approval of Minutes - Quarterly Meeting, July 26, 2018

III. Old Business

IV. New Business

1. Cancer Registry Research Data / Kristyn Vang **[vote required]**

2. Abortion Facilities regarding Planned Parenthood Appeals / Laura Shue, General Counsel **[vote required]**

3. Cosmetology Appeal – Phase One Cosmetology School / Vicki Pickering, Administrative Law Judge **[vote]**

4. Controlled Substance Emergency Rule / Laura Shue, General Counsel

5. Controlled Substance Rule / Laura Shue, General Counsel **[vote required]**

6. County Health Officer / Dr. Namvar Zohoori **[vote required]**

7. EMS / Brooks White, Administrative Law Judge: Chad Lance. This will be a recommendation for the Board to adopt the Proposed Findings of Fact and Conclusions of Law made by the three-member subcommittee which at the hearing on the case in August voted to recommend revocation of Mr. Lance's Paramedic license. **[vote required]**

8. EMS / Brooks White, Administrative Law Judge: Tony Meador: This will be a presentation of a proposed Consent Agreement for the Board's approval whereby Mr. Meador will consent to discipline in lieu of a disciplinary hearing if approved. **[vote required]**

9. EMS / Brooks White, Administrative Law Judge: Chris Hogan: This will be a presentation of a proposed Consent Agreement for the Board's approval whereby Mr. Hogan will consent to discipline in lieu of a disciplinary hearing if approved. **[vote required]**

V. Other Business

1. Administrative Updates

VI. Public Health Science/Program Updates

1. Science update / Dr. Namvar Zohoori
2. Hepatitis A outbreak update / Dr. Dirk Haselow
3. Program updates / Deputy Director Stephanie Williams

VII. President's Report

VIII. Director's Report

ABORTION FACILITIES REGARDING PLANNED PARENTHOOD APPEALS

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

MEMORANDUM

TO: BOARD OF HEALTH MEMBERS

FROM: Laura Shue, General Counsel

DATE: October 16, 2018

RE: Arkansas Department of Health v. Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains

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Attached please find documents submitted by the petitioner Arkansas Department of Health (ADH) and respondents Little Rock Family Planning Services (LRFPS) and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains (PPAEO).

The parties have agreed to submit this matter by the attached written pleadings and without oral presentation.

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH **PETITIONER**

V.

PPGP and LRFPS **RESPONDENT**

STATUTORY AUTHORITY

This Notice of Hearing is issued under the authority vested in the Arkansas Department of Health pursuant to Ark. Code Ann. § 20-9-302 et. Seq and Ark. Code Ann. § 20-7-101 et.Seq.

STATEMENT OF FACTS

A complaint was received by the agency regarding the three licensed abortion facilities.
The complaint was subsequently investigated:
Planned Parenthood of Arkansas and Eastern Oklahoma on 1/25/18,
Little Rock Family Planning Services on 1/30/18 and
Planned Parenthood of Arkansas and Eastern Oklahoma on 2/01/18.

Evidence of noncompliance with Ark. Code Ann §20-16-1703(d) was identified. Notification of regulatory noncompliance was provided by letter:

Planned Parenthood of Arkansas and Eastern Oklahoma dated 3/23/18,
Little Rock Family Planning Services dated 3/13/18 and
Planned Parenthood of Arkansas and Eastern Oklahoma dated 3/23/18

STATEMENT OF LAWS

Ark. Code Ann §20-16-1703(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight- hour reflection period required in this section.

ORDER

In lieu of an in person hearing before a subcommittee of the Board of Health the parties have agreed to the following schedule for document submission.

PPGP/LRFPS initial submission - Sept. 6 2018

ADH Response Sept. 27, 2018

PPGP/LRFPS Reply -- Oct. 11, 2018.

Final record submission to Board- Oct. 11, 2018

Board of Health meeting - Oct 25, 2018

Respondent is welcome to attend the Board of Health meeting Oct 25, 2018 at 10 AM in room 906 of Freeway Medical Bldg. 5800 West 10th Street Little Rock AR 72204. Board of Health meetings are public meetings.

Date

Bettina E. Brownstein
Bettina E. Brownstein Law Firm
904 W. Second St
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: *bettinabrownstein@gmail.com*
September 6, 2018

Hand Delivered

RECEIVED

SEP 0 6 2018

LEGAL DIVISION

VIA HAND DELIVERY

Mr. Reginald Rogers, Esq.
General Counsel's Office
Arkansas Dept. of Health
4815 W. Markham St., Slot 331
Little Rock, Arkansas 72205-3867

Re: In the Matter of Arkansas Dept. of Health v. Little Rock Family Planning Services, Inc. and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains

Dear Mr. Rogers:

In accordance with the Notice of Hearing issued in the referenced matter, enclosed please find Respondents' initial submission, which is due today.

Cordially,

Bettina E. Brownstein

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH — PETITIONER

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

BRIEF IN SUPPORT OF APPEALS OF DEFICIENCY FINDINGS AND MOTION TO DISMISS DEFICIENCY CITATIONS

The Basis for the Appeals

Respondents Little Rock Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood of Great Plains ("PPAEO"), submit this brief and motion to dismiss in support of their appeals of deficiency citations contained in a Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 13, 2018 to LRFPS, and Statements of Deficiencies issued to PPAEO's health centers in Fayetteville and Little Rock on March 23, 2018. The grounds for their appeals are:

(1) The statute upon which the citations are based, A.C.A. § 20-16-1703(d), as now interpreted by ADH, ("the Payment Ban"), violates the takings clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 22 of the Arkansas Constitution;

(2) The Payment Ban violates the equal protection clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 18 of the Arkansas Constitution;

(3) The Payment Ban violates the privacy rights of Respondents' patients, as guaranteed by the U.S. and Arkansas Constitutions;

(4) The Payment Ban violates the Contracts Clause of the U.S. Constitution, Art. 1, § 10.

(5) The Payment Ban constitutes tortious interference with contract in violation of Arkansas common law;

(6) ADH exceeded its authority in issuing the deficiency citations absent a regulation or rule prohibiting this conduct, and, under A.C.A. § 20-7-109(e), its interpretation of the law as prohibiting payment for services provided at a patient's first visit until the lapse of 48 hours interferes with the practice of medicine;

(7) Issuance of the deficiency citations was arbitrary and capricious, as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit before the lapse of 48 hours; and

(8) Issuance of the deficiency citations was arbitrary and capricious as PPAEO's practice of gathering credit card information at the first visit and then charging patients for services only after a delay of at least 48 hours complies with A.C.A. § 20-16-1703(d).

Introduction

Passed in 2015, A.C.A. § 20-16-1703(d) prohibits a health center from collecting payment from women for a "service provided in relation to abortion" until the completion of the state's 48-hour mandatory delay before an abortion may be obtained. *The state itself mandates* that clinicians provide certain counseling and ultrasound services, and that they do so at least 48 hours before a patient returns for an abortion. Yet the Payment Ban – contravening uniform standard medical practice – precludes collecting payment for these services at the time they are rendered. Without just compensation, the Payment Ban deprives abortion providers of their state-recognized property interest in their professional earnings. It violates providers' right to equal protection under the law because payment for abortion-related services is singled out for differential treatment from payment for all other medical services, for which patients may be

charged at the time the services are provided. In addition, the Payment Ban erodes Respondents' ability to keep their patients' most intimate, medical information private and violates the contractual relationship between providers and patients. ADH exceeded its authority in issuing the deficiency citations and its actions in doing so were arbitrary and capricious. And for PPAEO, the deficiency citation is unlawful for the additional, independent reason that its practice of collecting credit card information at the first visit, but not charging patients until after expiration of the mandated period, fully complies with the statutory text. For these reasons and others listed above and discussed below, Respondents urge the ADH Board of Health to grant their motion to dismiss the deficiency citations.

Statutory Context

As part of the state's informed-consent mandate, a woman seeking an abortion must receive counseling, have an ultrasound to determine whether there is embryonic or fetal cardiac activity, and receive state-mandated informational materials. § 20-16-1703(b)(1). The counseling must be provided in person at least 48 hours before the abortion, thus legally mandating that a woman make two trips to the providing facility. *Id.* In practice, the ultrasound is also performed at this initial visit so that, among other things, the physician can provide the information required by the mandatory counseling statute. *See* Affidavit of Lori Williams, Exh. 1, Brief and Affidavit of Melany Helinski, Exh. 2, Brief. As further detailed below, Respondents had historically charged patients for the services provided at the first visit and then, if the patient returned for an abortion after the expiration of the 48-hour delay, Respondents charged patients at that time for the abortion. However, according to A.C.A. § 20-16-1703(d), a physician "shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 48-hour reflection

period required in this section." As interpreted by ADH, that means that Respondents are prohibited from collecting payment for services provided at the first visit until the expiration of the 48-hour mandatory delay period. But, for a number of reasons, some women do not return again after the burdensome 48-hour mandatory delay.[1] This means that the Payment Ban impedes Respondents' ability to *ever* recover fees for first-visit services from those women who do not return, resulting in a significant financial loss to Respondents.

Failing to comply with the provision subjects a physician to criminal prosecution, civil penalties, findings of unprofessional conduct, and license suspension or revocation. §§ 20-16-1709, 1710. The Payment Ban forces abortion providers either to risk their patients' constitutionally protected privacy rights by attempting to contact them by telephone and/or sending them paper bills in an attempt to recover the fees for services provided at the first visit, or to forego payment entirely for these services. *See* Exhs. 1 and 2. The Payment Ban thus serves only to undermine patients' trust that they can receive high-quality care without having to sacrifice their privacy.

Procedural History

LRFPS received a Statement of Deficiencies from ADH on March 13, 2018, which stated that LRFPS was in violation of A.C.A. § 20-16-1703(d). PPAEO's health centers also received letters from ADH on March 13, 2018, seeking additional information about PPAEO's collection of credit card information (but not payment) on a patient's first visit for those first-visit services. It was unclear from these letters whether ADH had determined that PPAEO's practice of

[1] A woman may not return for the second visit because of the many logistical and financial barriers associated with Arkansas's mandate that she make a second trip to the facility such as: travel costs (particularly if she is travelling a far distance), the need to arrange child care, the need to take additional time off from work, the need to keep the abortion private from others, among other barriers. *See* Exhs. 1 and 2

collecting credit card information complied with the law. Then, on March 23, 2018, ADH sent revised letters to PPAEO Little Rock and Fayetteville health centers clarifying that it considered the collection of credit card information a deficiency and violation of the law.

Within the 10-day allowed period, Respondents disputed the legitimacy of the citations and requested a hearing before the Arkansas Board of Health ("the Board"), in accordance with A.C.A. § 20-15-208. Respondents have agreed to a joint hearing on their administrative appeals of the citations.

Respondents' Medical and Billing Procedures

Consistent with widespread medical practice, Respondents historically charged patients for first-visit services at the time those services were provided. After passage of A.C.A. § 20-16-1703(d), LRFPS continued this practice, which approach was validated when, following an inspection by ADH in 2016, it was found in compliance with all applicable ADH rules and regulations and was not cited for any violation of § 20-16-1703(d). *See* Exh. 1. On July 14, 2016, ADH again inspected LRFPS. Following this inspection, ADH issued a Statement of Deficiencies citing violation of §20-16-1703(d) as the basis for a deficiency citation. After an appeal, ADH subsequently dismissed the citation, agreeing with LRFPS that ADH lacked authority to issue it because it had no authority over physician conduct and there was no rule or regulation covering the particular conduct involved. *See* Exh. 1.Therefore, LRFPS continued charging for first-visit services at the time provided until it received the deficiency citation that is the subject of its appeal.

Following passage of § 20-16-1703(d), PPAEO initially ceased charging patients for any first-visit services at the time of the first visit. But due to the financial losses, PPAEO experienced as a result of not charging patients at the time of the first visit, PPAEO instituted the

practice of obtaining credit card information from the patient at the time of the first visit, but not submitting any credit card charges until (at the soonest) the expiration of more than 48 hours. *See* Exh. 2. Collecting credit card information at the first visit but not charging patients until after the expiration of the 48-hour period is consistent with A.C.A. § 20-16-1703(d), which provides only that a provider "shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section."

Since the deficiency citations were received that are the subject of this appeal, Respondents have refrained from charging for services or obtaining credit card information from patients at the time of the first visit. *See* Exhs. 1 and 2. Instead, if patients do not return for a second visit to obtain an abortion, have indicated they do not intend to obtain an abortion, or are otherwise ineligible for an abortion, Respondents send them an invoice by mail after at least 48 hours have passed, and attempts -- often unsuccessfully - to obtain payment in this manner. *See* Exhs. 1 and 2. On occasion, if the patient has expressed concern about receiving mail, PPAEO will attempt telephone contact -- also after the expiration of at least 48 hours. *See* Exh. 2. If a patient does return for her abortion, she is then charged for the medical services rendered at both visits. *See* Exhs. 1 and 2. In no instance, at the present time, is payment requested by either Respondent for services provided at the first visit prior to the elapse of 48 hours. *See* Exhs. 1 and 2.

Respondents' First-Visit Services

At all times, both before and after the issuance of the deficiency citations, during the first visit to LRFPS or PPAEO, a woman is given information in accordance with § 20-16-1703. A patient who desires an abortion then undergoes an ultrasound administered by qualified staff and

interpreted by physicians. The ultrasound determines the location of pregnancy (intrauterine or ectopic), how many weeks the pregnancy has advanced, whether the pregnancy is ongoing, and whether there is embryonic or fetal cardiac activity. (If the pregnancy is not ongoing, the woman may receive immediate medical care to manage her pregnancy loss, or a referral to a medical provider of her choice.)

The ultrasound is necessary at the first visit to comply with state-mandated requirements including (1) to determine whether there is embryonic or fetal cardiac activity, and, if so, to inform the patient of that fact, A.C.A. § 20-16-1303; (2) to inform the patient of how many weeks the pregnancy has advanced and of the "probable anatomical and physiological characteristics of the" embryo or fetus, *id.*; § 20-16-1703(b)(1)(C-D); and (3) to describe "the proposed abortion method," *id.*; § 20-16-1703(b)(1)(B)(i). State law mandates that the physician provide this information, which is dependent on ultrasound, at least 48 hours before the abortion. *Id.*; § 20-16-1703(b)(1); *See* Exhs. 1 and 2. A provider who fails to comply with these mandates would face criminal charges, civil liability, and termination of his or her medical license. §§ 20-16-1709, 1710.

Inasmuch as state law requires an abortion patient to travel twice to a clinic, at least 48 hours apart, providing the ultrasound at the first visit also reduces the risk that a patient will have to return unnecessarily -- and suffer further delay -- if the ultrasound reveals that she is not eligible for an abortion at that clinic if, for example, her pregnancy has advanced beyond the point that that clinic provides abortion care. *See also fn. 1.*

If there are any signs of an ectopic pregnancy, the woman is referred on an urgent basis for additional care. If the woman has an intrauterine pregnancy, is within the period of pregnancy during which the health center provides abortions, and desires an abortion, a licensed

nurse under the direction of a physician and a physician provide the information the state mandates for the woman to be able to give informed consent for an abortion.

Payment for Services at LRFPS and PPAEO

At LRFPS, prior to March 13, 2018, payment for the ultrasound, lab work, and mandated informed consent counseling was obtained at that visit. If the patient returned for an abortion, she was charged at that time for her abortion care. *See* Exh. 1. Since the deficiency was issued on March 13, 2018, if the woman does not return to LRFPS, she is billed by mail via the U.S. Postal Service at the mailing address she provided during her first visit. *See* Exh. 1. The invoice states that payment is due upon receipt. If no payment is received, the patient is billed once again after an additional 30 days. *See* Exh. 1.

At PPAEO, prior to the passage of A.C.A. § 20-16-1703(d), PPAEO patients were charged at the first visit for the ultrasound, lab work, and mandated informed consent counseling, and payment was required that same day. If the patient returned for the second visit to terminate her pregnancy, she was charged for her medication abortion (the only abortion method PPAEO provides). *See* Exh. 2. After passage of A.C.A. § 20-16-1703(d), PPAEO initially did not accept any payment or collect any credit card information at the first visit. Then, beginning in February 2017 through March 23, 2018, PPAEO collected credit card information at the first visit but did not process the information until the patient's pregnancy had progressed past the range for a medication abortion, or the patient had affirmatively stated she did not plan to have an abortion at a PPAEO health center, and always at least 48 hours after the first visit. *See* Exh. 2. Generally, significantly more than 48 hours was allowed to pass to give the patient an opportunity to return for the abortion. In the majority of cases, the credit card charges did not go through when PPAEO attempted to process the credit card, and PPAEO then attempted to collect

payment by sending the patient a hard copy bill. *See* Exh. 2. Since March 23, 2018, PPAEO has not collected any payment or credit card information prior to the lapse of 48 hours after the patient's first visit. If a patient returns for her abortion, at that time she is billed for both her procedure and her first-visit services. If a woman does not return for the abortion, PPAEO mails a hard copy bill to the patient for the first-visit services. a *See* Exh s 2

The Evidence

The evidence contained in Exhibits 1-3 shows that LRFPS and the PPAEO have experienced significant loss of revenue as a result of ADH's current interpretation of § 20-16-1703(d) as prohibiting payment at the first visit for physician charges for ultrasounds and other first-visit services. From February 1, 2017 to March 22, 2018, PPAEO lost $10,961.66 in patient revenue. *See* Affidavit of Nathan Johnson, Exh.3, Brief. Fifty-seven women did not return for an abortion and have unpaid balances[2] for this period. LRFPS had a loss of $20,000 in-patient revenue from March 1, 2018 to September 5, 2018. *See* Exh.1.One hundred and two patients who did not return for an abortion and who were billed for first visit services during this same period, did not pay for these services. *See* Exh. 2.

The evidence shows that, based upon Respondents' experience, this rate of payment delinquency is not unexpected and is the reason why most medical providers charge for services on the same day they are received. Insurance or other third-party payment is not available for ultrasounds and the other first-visit services; thus, the only means to ensure payment for these physician and other professional services is to charge a patient before the service is provided. *See* Exhs. 1-3. In addition to the loss of revenue from patients, Respondents incur additional

[2] As of the date of this motion and brief, PPAEO, due to the intermittent nature of the paper billing, is unable to ascertain its total lost revenue since it ceased collecting credit card information on March 24, 2018.

expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if not for the Payment Ban. These additional expenses are estimated at $540 for LRFPS. *See* Exh.. There is an additional expense for PPAEO associated with attempts to collect payment by paper billing. *See* Exh. 3.

No health care provider in the state other than an abortion provider is prohibited from charging for services until 48-hours has elapsed. For instance, plastic surgeons, and oral surgeons and dentists, when their services are not covered by insurance, charge for services when rendered. No law prevents them from doing so. Exhibits 1-3.

The Payment Ban Is Unconstitutional under Both the Federal and Arkansas Constitutions as a Taking Without Just Compensation

The statutory prohibition on charging for an ultrasound and other first-visit services before the lapse of 48 hours constitutes an unconstitutional takin without just compensation under the Takings Clause of both the Fifth Amendment to the U.S. Constitution (made applicable to the states by the Fourteenth Amendment) and Article 2, § 22 of the Arkansas Constitution. The Fifth Amendment provides that "private property" shall not "be taken for public use, without just compensation." *Chicago, B. & Q.R. Co. v. Chicago*, 166 U.S. 226, 239 (1897); *Penn Central Transportation Company, v. City Of New York*, 438 U.S. 104, 122 (1978).

A legitimate property interest is "determined by reference to existing rules or understandings that stem from an independent source such as state law." *Phillips v. Washington Legal Foundation*, 524 U.S. 156, 163–64 (1998) (internal citation and quotation marks omitted). "[A]t least as to confiscatory regulations (as opposed to those regulating the use of property), a State may not sidestep the Takings Clause by disavowing traditional property interests long recognized under state law." *Id.* at 167 (internal citation and quotation marks omitted).

Government has the authority to confiscate private property, but it imposes two conditions on the exercise of such authority: the taking must be for a "public use" and "just compensation" must be paid. *Brown v. Legal Foundation of Washington*, 538 U.S. 216, 232 (2003). The Arkansas Constitution has a similar provision: "[P]rivate property shall not be taken, appropriated or damaged for public use, without just compensation therefor." Art. 2, Sec. 22.

The Arkansas Supreme Court has decreed that the right to payment for medical services is a property interest protected by both the federal and Arkansas constitutions. In *Arnold v. Kemp*, 306 Ark. 294 (1991), the Court found that a state statute that capped attorneys' fees paid to counsel appointed to represent indigent criminal defendants represented a taking without just compensation under both the Fifth Amendment and Arkansas Constitution and declared the statute unconstitutional. The Court said,

> Attorneys, like the members of any other profession, have for sale to the public an intangible---their time, advice, and counsel. Architects, engineers, physicians, and attorneys ordinarily purvey little or nothing which is tangible. It is their learned and reflective thought, their recommendations, suggestions, directions, plans, diagnoses, and advice that is of value to the persons they serve. It is not the price of the paper on which is written the plan for a building or a bridge, the prescription for medication, or the will, contract, or pleading which is of substantial value to the client; it is the professional knowledge which goes into the practice of the profession which is valuable.
>
> Attorneys are licensed by the state to practice their profession; but so are other professionals, such as architects, engineers, and physicians. One who practices his profession has a property interest in that pursuit which may not be taken from him or her at the whim of the government without due process.
>
> Attorneys make their living through their services. Their services are the means of their livelihood. We do not expect architects to design public buildings, engineers to design highways, dikes, and bridges, or physicians to treat the indigent without compensation.
>
> When attorneys' services are conscripted for the public good, such a taking is akin to the taking of food or clothing from a merchant or the taking of services from any other professional for the public good.

Id. at 301.

The recognition by the Supreme Court of Arkansas that payment for professional services, including professional medical services, is property means that these earnings are protected property interests under both the federal and state constitutions. *See Phillips v. Washington 524 U.S. at 163- 64; Burns v. Brinkley*, 933 F. Supp. 528, 532 (E.D. N.C. 1996). The Court in *Burns* explained that the U.S. Constitution looks to state law to determine what constitutes a protected property right. *Id.* (citing *Cleveland Bd. of Educ. v. Loudermill.* 470 U.S. 532, 538 (1985)). Thus, payments for the medical services provided by Respondents are protected property rights that cannot be abrogated under either the U.S. or Arkansas constitutions absent just compensation.

The evidence shows that banning payment at the time of a patient's first visit to Respondents means that their physicians and other licensed staff are forced to provide services without compensation. *See* Exhs 1-3. Just as requiring the attorneys in *Arnold v. Kemp* to provide services without compensation was an unconstitutional takings in violation of both the federal and state constitutions, forcing Respondents and their physicians to perform certain services in order to comply with the law and then making them forgo compensation for these services is also an unconstitutional taking without just compensation.

In addition, there is no evidence that banning payment for 48 hours furthers any public purpose or use. The only evidence of any purpose behind the enactment of §20-16-1703(d) is contained in Act 1086, codified at § 20-16-1709, "Legislative finding and purposes." *See* Act 1086, Exhi. 4 to Brief. An examination of these findings and purposes shows that all are concerned with ensuring that a woman possess adequate information to make an informed decision as to whether to terminate her pregnancy. The Payment Ban has no impact on this. The

evidence shows that a woman receives the same information prior to giving informed consent (or not), irrespective of the timing of payment. *See* Exhs. 1 and 2. In the absence of any public purpose whatsoever for taking Respondent's protected professional earnings, the Payment Ban is unconstitutional and should be invalidated.

The Payment Ban Violates the Equal Protection Provisions of the Federal and Arkansas Constitutions

The Equal Protection Clause of the Fifth Amendment is "essentially a direction that all persons similarly situation should be treated alike." *Stevenson v. Blytheville School Dist. #5*, 800 F.3d 955, 970 (8th Cir. 2015) (quoting *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985)) (internal quotation marks omitted.) The Equal Protection Clause of the Fourteenth Amendment states in pertinent part, " . . . nor shall any state . . . deny to any person within its jurisdiction the equal protection of its laws."

The Arkansas Constitution imposes a similar requirement. Article 2, Section 3 of the Arkansas Constitution states, "The equality of all persons before the law is recognized and shall ever remain inviolate; . . ." Article 3, Section 18 of the Arkansas Constitution states, "The General Assembly shall not grant to any citizen, or class of citizens, privileges or immunities which, upon the same terms, shall not equally belong to all citizens."

Under both the federal and Arkansas Constitution, while most laws may survive an equal protection challenge "if the distinction it makes rationally furthers a legitimate state purpose," *Zobel v. Williams*, 457 U.S. 55, 60 (1982), the state may not rely on a classification "whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne*, 473 U.S. at 446; *see Streight v. Ragland*, 280 Ark. 206, 213 (1983) (noting

that the same rational basis review applies to equal protection arguments raised under both the Arkansas and federal constitutions).[3]

The Payment Ban penalizes abortion providers and no other health care professionals, for no legitimate reason, much less a constitutionally-sufficient one. There is no other instance where the state forces a doctor to perform certain services, mandates the timing of those services, and then effectively disallows payment for those services. Because the law singles out abortion providers for disparate treatment without justification, it is unconstitutional under both the federal and Arkansas constitutions. *See Arnold v. Kemp* 306 Ark. 294, 304 (1991).

In *Arnold*, the Arkansas Supreme Court found that singling out certain attorneys to provide services to the indigent at a reduced rate of compensation violated the equal protection guarantees of the federal and Arkansas constitutions. In making this determination, the Court considered three factors: (1) the character of the classification, (2) the individual interests asserted in support of the classification, and (3) the governmental interests asserted in support of the classification. *Id.* It concluded that the burden to represent the indigent fell impermissibly on a subclass of attorneys. The Court found there was no rational basis for the disparate treatment, rejecting the state's argument that since only lawyers had the requisite license to practice law, the legislature "could take one step at a time in addressing complex problems." *Id.* Instead, the Court found that the legislature could not infringe upon the guaranteed constitutional rights of the citizens it represents, and that the burden to represent the indigent fell unequally on different lawyers. Therefore, lawyers' rights to equal protection were violated. *Id.* Just as was the case with the lawyers in *Arnold*, the Arkansas Legislature is impermissibly infringing on the

[3] Actually, the appropriate level of scrutiny to apply in these appeals' challenge under equal protection is heightened scrutiny, since the Payment Ban targets a woman's fundamental right to an abortion.

guaranteed constitutional rights of the citizens it represents, in this case abortion providers—and only abortion providers –are forced to render professional services without compensation. There is no rational basis for this punitive law, nor is there any reasonable relationship between the law and any purported purpose. While rational basis review does not "require a perfect or exact fit between the means used and the ends sought." *Walker v. Hartford Life & Accident Ins. Co.*, 831 F. 3d 968, 978-79 (8th Cir. 2016), it is "not toothless." *Kansas City Taxi Cab Drivers Ass.n LLC v. City of Kansas City, Mo.*, 742 F. 3d 807, 810 (8th Cir. 2014). Instead, equal protection review requires, at a minimum, that a statute's discriminatory line-drawing be rationally related to a legitimate state need. And here, the evidence shows no such relationship. There is simply no medical or other legitimate justification for prohibiting a physician from charging for services rendered to a patient at the time of service. Rather, the Payment Ban effectively prevents physicians who provide abortion from obtaining compensation for medical services they deliver – even though these medical services are mandated by Arkansas law. *See* Exh. 3. Indeed, the law appears motivated by animus toward abortion. Such motivation cannot provide a rational basis for denying compensation to abortion providers and no other type of health care provider.

The lack of a legitimate purpose for the Payment Ban is borne out by the only evidence of legislative intent behind this law, as discussed above. *See* Exh. 4. An examination of these findings and purposes shows that all are concerned with ensuring that a woman possess adequate information to make an informed decision as to whether to terminate her pregnancy. That purpose has no rational relationship to the Payment Ban: whether a woman receives the information to make an informed decision is not influenced by when payment for services already rendered is made. *See* Exhs 1 and 2. And, regardless of whether a woman obtains an abortion, she remains liable for payment for these first-visit services. Requiring delayed payment

for first-visit services does nothing to add to the information a woman has prior to her decision. Women receive the same state-mandated information and are required to observe the same 48-hour delay regardless of when payment is made. *See* Exhs 1 and 2. Thus, the prohibition on payment at the first visit does nothing to further any state interest in ensuring that women have sufficient information before choosing to have an abortion. And the state of course does not have a legitimate interest in "taking" a physician's legitimate compensation for services provided. *See* Exh. 4.

The Payment Ban Violates a Patient's Right to Privacy under the U.S. Constitution

The U.S. Constitution protects not only privacy in individual decision-making, but also "the individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977); *see McCambridge v. City of Little Rock*, 298 Ark. 219, 229 (1989) (recognizing a constitutional right to nondisclosure of "personal matters"); *see also Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (holding that the right protects "highly personal matters" in "the most intimate aspects of human affairs"); *Cooksey v. Boyer*, 289 F.3d 513, 515–16 (8th Cir. 2002) (same); *Alexander v. Peffer*, 993 F.2d 1348, 1349–50 (8th Cir. 1993) (same). By threatening disclosure of the identity of women who have sought abortions, the Payment Ban violates patients' constitutional right to informational privacy.

The Payment Ban creates a significant risk that confidential abortion information will be disclosed to third parties. Because of this statute, it is practically impossible to obtain payment for first-visit services from those patients who, for a variety of reasons – such as difficulties arranging transportation to travel (often for long distances), inability to take off from work, inability to arrange childcare, need to keep the abortion private, or being beyond the point in pregnancy at which the clinic provides abortion care – are unable to return for an abortion. *See*

Exhs 1 and 2. Respondents are forced instead to attempt to contact these patients by either telephone or mail to try to recover payment for these services. Both these methods carry significant risk of exposing the patient's visit to a third party. Telephoning presents the risk that other individuals will answer the provider's telephone call or overhear the conversation;[4] mailing a bill carries the risk that someone else will open the envelope with the bill. *See* Exhs. 1 and 2. Both types of communication may thus lead to the disclosure of confidential information that a woman is pregnant and considering an abortion. *See Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1042 (E.D. Ark. 2017) (finding that LRFPS "is a well-known abortion provider," so any communication relating to LRFPS necessarily "discloses that the patient likely is seeking an abortion"). While Respondents make their best efforts to minimize the chances that this personal information is disclosed through the collection process, *see* Exhs. 1 and 2, there remains a significant risk that a woman's confidential medical information will be disclosed. In contrast, if women were able to pay for the services at the first visit, there would be no need to contact these patients after the fact to obtain payment. *See* Exhs. 1 and 2. In this way the statute impermissibly risks disclosure of the identity of women who sought an abortion but did not return to the provider for the abortion appointment.

The Arkansas Supreme Court has held that the right to informational privacy under the U.S. Constitution protects "personal matters," meaning "information: (1) that the individual wants to and has kept private or confidential, (2) that, except for the challenged government

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[4] In addition, telephoning patients about outstanding bills requires additional resources that are unlikely to result in payment since many patients change phone numbers frequently or have phones that are often out of service. Exh. 2.

action, can be kept private or confidential, and (3) that to a reasonable person would be harmful or embarrassing if disclosed." *McCambridge v. City of Little Rock*, 298 Ark. 219, 230 (1989).[5]

A woman seeking an abortion meets all three of the *McCambridge* criteria. It is no secret that abortion can be a highly-charged, emotional issue. *See Jegley*, 267 F. Supp. 3d at 1076. Many patients are desperate not to reveal to anyone that they are pregnant and considering an abortion. *See* Exh. 1 and 2. For some women, disclosure of the fact that they sought an abortion could expose them to abuse. *See Jegley*, 267 F. Supp. 3d at 1076. (finding evidence in the record that "women fear hostility or harassment. . . for deciding to seek an abortion"). There is ample evidence that women who seek abortions in Arkansas are subject to hostility and harassment. *See PPAEO v. Jegley*, 4:15-cv-84, Prelim. Inj. Order, (June 18, 2018). Because a woman seeking an abortion typically (1) wants to keep her decision to seek an abortion private, (2) could keep it private but for the Payment Ban, and (3) might be harmed or embarrassed by its disclosure, her abortion decision is a "personal matter" entitled to constitutional protection under Arkansas Supreme Court precedent.

A woman also has a protectable privacy interest in her abortion-related information under U.S. Supreme Court and Eighth Circuit precedent. In the Eighth Circuit, the right to informational privacy applies where disclosure would be "a shocking degradation or an egregious humiliation," or "a flagrant bre[a]ch of a pledge of confidentiality which was instrumental in obtaining the personal information." *Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (quoting *Alexander v. Peffer*, 993 F.2d 1348, 1350 (8th Cir. 1993)). Constitutional

[5] Arkansas state courts are bound by the Arkansas Supreme Court's interpretation of federal law. *See Lockhart v. Fretwell*, 506 U.S. 364 (1993) (Thomas, J., concurring) ("An Arkansas trial court is bound by [the United States Supreme] Court's (and by the Arkansas Supreme Court's and Arkansas Court of Appeals') interpretation of federal law. . . .").

protection turns on "the nature of the material" and whether the person has "a legitimate expectation that the information would remain confidential." *Id.*

The decision to have an abortion "involves some of the most intimate and personal aspects of a woman's life." Jegley, 267 F. Supp. *at* 1095 A woman has a legitimate expectation that information revealed to her physician will remain confidential. *See, e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001) ("The reasonable expectation of privacy enjoyed by the typical patient . . . is that [her medical information] will not be shared with nonmedical personnel without her consent."). As a form of medical information, abortion-related information is a "categor[y] of data which, by any estimation, must be considered extremely personal." *Eagle*, 88 F.3d at 625. The involuntary disclosure that a woman sought an abortion could cause a woman to suffer "a shocking degradation" or "egregious humiliation," *Jegley*, 267 F. Supp. 3d at 1093, in part because of the violence and abuse that might ensue. Accordingly, as the Eastern District of Arkansas recently concluded, abortion information lies at the core of informational privacy under the Eighth Circuit's standard. *See Jegley*, 267 F. Supp. at 1095 (finding a likelihood of success on informational privacy claim based on disclosure of a minor's abortion to local law enforcement).[6] For all these reasons, patients have a strong, constitutionally-protected interest in avoiding disclosure of their sexual activity and their desire to seek an abortion.

A law invading constitutionally-protected privacy can be upheld only if a substantial government interest outweighs the burdened privacy right. *See McCambridge*, 298 Ark. at 231

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[6] *See also Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 553 (9th Cir. 2004) (informational privacy protections triggered by requirement to disclose abortion patient records to state); *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 371 (4th Cir. 2002) (applying informational privacy doctrine to abortion information, but finding no constitutional violation because of adequate "recordkeeping and information reporting mechanisms").

(citing *Nixon v. Administrator of General Servs.*, 433 U.S. 425, 456–57 (1977)); *see also Taylor v. United States*, 106 F.3d 833, 837 (8th Cir. 1997) (concluding "that the government has the requisite interest" in disclosure and that the statute "is sufficiently related to such interest . . . to pass constitutional muster"). The Payment Ban is purportedly designed to ensure a woman's informed consent to an abortion, *see* Exh. 4, but as described at length above, prohibiting providers from collecting payment for services *already* provided—payment for which a woman remains liable *regardless of whether she obtains an abortion, or does so at the same clinic where she received the first-visit services*—does nothing to ensure her informed consent.

In fact, this risk of a "breach of confidentiality" may "interfere with a woman's right to decide to end a pregnancy" and "cause [her] to for[e]go abortion in Arkansas rather than risk disclosure" of the fact that she sought an abortion. *Jegley*, 267 F. Supp. 3d at 1076; *see also Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1462 (8th Cir. 1995) (recognizing the harm of a parental notice statute because "parents who differ from their [minor] daughters on religious or moral grounds over abortion" might go so far as to "prevent their daughters from obtaining abortions"); *Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1061 (D.S.D. 2011) (finding that a woman may choose to forego her abortion rather than disclose her decision to a Pregnancy Help Center). There is no state interest that outweighs this risk, and so the law fails any constitutional balancing and impermissibly infringes on Respondents' patients' constitutional right to informational privacy.

The Payment Ban Also Violates Patients' Right to Privacy Under the Arkansas Constitution

Implicit in the Arkansas Constitution is "a fundamental right to privacy" that triggers strict scrutiny review. *Jegley v. Picado*, 349 Ark. 600, 632 (2002); *see also Zimmerman v. Pope*, 2015 Ark. App. 499 (2015) (applying *Picado*). Recognizing the state's "rich and compelling

tradition of protecting individual privacy," the Arkansas Supreme Court has held that the state constitution provides even *greater* privacy protection than the U.S. Constitution. 349 Ark. at 631. *Picado* contemplates that a statute like the Payment Ban, which "discloslesl [a woman's] records" and results in "an unwarranted invasion of personal privacy," violates her fundamental right to privacy. 349 Ark. at 631. "When a statute infringes upon a fundamental right, it cannot survive unless 'a compelling state interest is advanced by the statute and the statute is the least restrictive method available to carry out [the] state interest.'" *Picado*, 349 Ark. at 632 (quoting *Thompson v. Arkansas Social Services*, 282 Ark. 369, 374 (1984)). Even if the statute at issue here could survive a lesser balancing test (which it cannot), it certainly could not survive strict scrutiny: the method by which the Payment Ban operates is not just more restrictive than necessary, but *entirely unrelated* to its supposed purpose of ensuring a woman's informed consent. As explained above, a woman remains liable for the bill for first-visit services, *regardless of whether she returns to the same clinic for an abortion*, and so the law does nothing to inform her decision. Because it fails strict scrutiny review, the Payment Ban also violates patients' right to informational privacy under the Arkansas Constitution.

The Statute Violates the Federal Contracts Clause

The Contracts Clause of the federal Constitution provides that "[n]o state shall . . . pass any . . . Law impairing the Obligation of Contracts." U.S. Const., Art. I, § 10, cl. 1. Courts generally apply a two-step test when analyzing a claim under the Contracts Clause. *See, e.g., Gen. Motors Corp. v. Romein*, 503 U.S. 181 (1992). Courts first determine "whether the state law has 'operated as a substantial impairment of a contractual relationship.'" *Id.* at 186. In answering this question, courts consider "whether there is a contractual relationship, whether [the] law impairs that contractual relationship, and whether the impairment is substantial." *Id.* If

there is a substantial impairment of the contractual arrangement, courts then assess "whether the state law is drawn in an 'appropriate' and 'reasonable' way to advance 'a significant and legitimate public purpose.'" *Sveen v. Melin*, 138 S. Ct. 1815, 1822 (2018) (citing *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411–12 (1983)).

In this instance, the evidence shows that the Payment Ban operates to substantially impair the contractual arrangement between the abortion provider and the patient. *See* Exh 1–3. The providers and their physicians stand in a contractual relationship with the individual patient in rendering medical services. The Payment Ban unarguably constitutes a substantial impairment of Respondents' ability to receive compensation under this arrangement. *See* Exhs 1 and 3. More specifically, the Payment Ban interferes with a health care provider's reasonable expectation of payment for professional services, and prevents the health care provider from safeguarding the right to compensation for these services. *See Sveen*, 138 S. Ct. at 1822.

The Payment Ban Tortiously Interferes with Respondents' Contractual Relationships with Their Patients

Arkansas recognizes the tort of interference in situations involving contract or business expectancies between a physician and patient. *See LasikPlus Murphy, M.D., P.A. v. VCI-Vision, Inc.*, 776 F. Supp. 2d 886, 897 (E.D. Ark. 2011) (citing *Baptist Health v. Murphy*, 373 S.W.3d 269, 284 (Ark. 2010)). The elements of tortious interference with contractual rights are: "(1) the existence of a valid contractual relationship or business expectancy; (2) knowledge of the relationship or expectancy on the part of the interferer; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage to the party whose relationship or expectancy has been disrupted." *Walt Bennett Ford, Inc. v. Pulaski City Special School Dist.*, 274 Ark. 208, 214 (Ark. 1981). These four elements are easily met in this case.

Respondents indisputably enter into valid contractual relationships with individual patients at their initial visit. (1) The parties are competent; (2) there is a subject matter upon which a contract can operate (medical services); and (3) legal consideration, as well as mutual agreement and mutual obligation, are present (medical services rendered in exchange for payment). *See City of Dardenelle v. City of Russellville*, 372 Ark. 486, 490 (Ark. 2008) (listing the "essential elements of a contract" as "(1) competent parties, (2) subject matter, (3) legal consideration, (4) mutual agreement, and (5) mutual obligation"). ADH is aware of this contractual relationship and that Respondents depend on patient fees to pay for the ultrasound and other first-visit services.

Damages result from enforcement of the Payment Ban. *See* Restatement (Second) of Torts § 774A (Am. Law. Inst. 1979) (damages for interference include "the pecuniary loss of the benefits of the . . . prospective relation . . . [and] consequential losses for which the interference is the legal case"). Dr. Thomas Tvedten is the owner of LRFPS, and the loss of patient revenue due to the Payment Ban falls directly to him. *See* Exh. 1. The loss of patient revenue affects the ability of PPEAO's clinics to provide a livelihood to its physicians and professional staff. Exh, 3. LRFPS has experienced a loss of revenue of $20,540 since the issuance of the Statement of Deficiencies. *see* Exh. 1. PPAEO has experienced a loss of $10, 961.66 since February 2017 to March 23, 2018 and more since that date. *See* Exh.3. Because of this interference with Respondents' contractual relationships with their patients and the attendant damages they experience, the Payment Ban should be invalidated.

ADH Exceeded Its Authority in Issuing the Statements of Deficiencies Because There Is No Regulation or Rule Prohibiting the Conduct Cited, and ADH's Current Interpretation of the Statute Impermissibly Regulates the Practice of Medicine

A previous deficiency citation issued by ADH to LRFPS on August 5, 2016 was dismissed after an appeal because there was no Board rule or regulation governing LRFPS's practice of charging patients for an ultrasound and other services at the time the services were provided. Robert Brech, then General Counsel for ADH, recognized that absent such a rule or regulation, ADH lacked the authority to issue the citation. *See* Brech Aug. 25 Letter, Exh. B to Exh. 1. The conduct cited in the March 23, 2018, Statement of Deficiencies is identical to that dismissed previously. However, no pertinent regulation or rule has ever been promulgated by the Board. Therefore, for the same reason the August 5, 2016 deficiency citation was dismissed, the citations that are the subject of these appeals should meet the same fate.

In addition, even if there *were* a rule or regulation on this issue, Arkansas law makes clear that the Board "shall not regulate the practice of medicine or healing nor interfere with the right of any citizen to employ the practitioner of his choice." A.C.A. § 20-7-109. Banning payment for services provided at a patient's first visit until the lapse of 48 hours unquestionably constitutes regulation of Respondents' physicians' practice of medicine. ADH's current interpretation of the statute interferes with both the timing and method of payment by patients (resulting in nonpayment for a significant proportion of services provided). Absent the Payment Ban, Respondents would require payment for first-visit services at the time of service, thus avoiding the loss of revenue due to the delay in billing. Therefore, ADH lacks authority to issue the citations that are the subject of this appeal: no rule or regulation allows the citations, and the citations violate § 20-7-109 (c) in attempting to regulate when and how Respondents can charge for their medical services.

The Issuance of the Statements of Deficiency to LRFPS Was Arbitrary and Capricious

ADH's issuance of the deficiency citations was arbitrary and capricious as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit and before the lapse of 48 hours. *See* Exh. 1. A subsequent deficiency citation was dismissed. *See Exh. 2.* ADH's about-face in its interpretation of the law is unjustified as LRFPS's practice of charging patients at the first visit, which previously was found to be in compliance with ADH's rules and regulations, is identical to its practice subsequently found to warrant a deficiency citation. This fits the very definition of arbitrary and capricious.[7]

Collecting Credit Card Information Does Not Constitute "Requiring" or "Obtaining" Payment and ADH's Citation of this Practice Was Arbitrary and Capricious.

In any event, PPAEO acted lawfully when it collected credit card information from its patients during their first visit to the clinic, so PPAEO's citations must be withdrawn. ADH's citation of this practice was arbitrary and capricious and not supported under Arkansas law. The statute at issue prohibits an abortion provider from "requir[ing] or obtain[ing] payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period" mandated by law. A.C.A. § 20-16-1703(d). Under Arkansas law, the Board must construe this statute "just as it reads, giving words their ordinary and usually accepted meaning in common language." *Arkansas Dep't of Correction v. Shults*, 2018 Ark. 94, 4, 541 S.W.3d 410, 412 (2018). Language that was not included by the legislature will not be read into the statute. *Id.* If the "statute is

[7] BLACK'S LAW DICTIONARY, 112, 224, 8th ed. (1999) "Arbitrary: Founded on prejudice or preference rather than on reason or fact. "Capricious: Contrary to the evidence or established rule of law."

ambiguous, th[e] court must interpret it according to legislative intent," and the court's "review becomes an examination of the whole act." *Dickinson v. SunTrust Nat'l Mortg. Inc.*, 2014 Ark. 513, 4, 451 S.W.3d 576, 579 (2014).

The plain language of the statute prohibits only "obtain[ing] payment" or "requir[ing] . . . payment" for an abortion-related service during the mandatory delay. Ark. Code § 20-16-1703(d). Three words are at issue here: "obtain," "require," and "payment." Given its most natural meaning, a payment is a transfer of money. *See Pay*, *Merriam-Webster Online Dictionary* (2018). https://www.merriam-webster.com/dictionary/pay ("to make a disposal or transfer of (money)" or "to give in return for goods or service"); *Payment*, *Merriam-Webster Online Dictionary* (2018), https://www.merriam-webster.com/dictionary/payment ("something that is paid"). To obtain a payment is "to gain or attain [it,] usually by planned action or effort." *Obtain*, *Merriam-Webster Online Dictionary* (2018), https://www.merriam-webster.com/dictionary/payment. To require a payment is "to claim or ask for [it] by right and authority" or "to demand [it] as necessary or essential." *Require*, *Merriam-Webster* (2018), https://www.merriam-webster.com/dictionary/payment. By merely takings a woman's credit card information, but not submitting any charges, PPAEO neither obtains nor requires payment.

First, and simply, PPAEO does not improperly "obtain payment" because it does not "gain or attain" any money during the 48-hour delay. Money from the patient's bank account does not transfer to PPAEO until (if the credit card transaction is successful) the moment her card is charged. And second, taking credit card information is not the same thing as requiring payment. If it were, every online retailer with its customers' credit card information on file would have the "right and authority" to "demand [payment] as necessary or essential" at any time. Under the state's reading of the statute, a company like Amazon, which collects users'

credit card information when they sign up for the service, would be "requir[ing] . . . payment" before users even bought their first item. In the same way, an abortion facility has not "require[d]" payment for an abortion-related service unless and until the credit card information collected from the patient has been processed, which does not happen until after the 48-hour waiting period has elapsed. Under the plain text of the statute, collecting credit card information does not constitute "requiring" or "obtaining" payment.[8]

CONCLUSION

For the reasons asserted above, the Statements of Deficiencies should be dismissed and the Motion to Dismiss granted.

Dated: September 6, 2018

Respectfully submitted:

Bettina E. Brownstein (85019)
Bettina E. Brownstein Law Firm
904 W. Second St., Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com

[8] Even if the statute were ambiguous, the legislature's intent was to ensure a woman's informed consent to an abortion. *See* Exh. 4. Because collecting credit card information is unrelated to that purpose, the statute should not be read to prohibit obtaining credit card information.

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH — PETITIONER

V.

PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

Affidavit of Lori Williams

My name is Lori Williams. I am over the age of 21, competent and have personal knowledge of the matters testified to herein.

1. I am currently the Clinic Director at Little Rock Family Planning Services, PLLC ("LRFPS"). I submit this affidavit in support of LRFPS' appeal of the Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 13, 2018.
2. I am an Advanced Practice Nurse with an M.S.N. from Vanderbilt University. From 1999-2000, I worked as a labor and delivery nurse at Rebsamen Medical Center in Jacksonville, Arkansas. In 2000, I was employed at Women's Community Health Center in Little Rock as the nursing supervisor. I also had a gynecology practice. In 2003, I become employed at LRFPS, first as a women's health practitioner, then in 2004 as Associate Clinic Director. In 2007, I became Clinic Director. Thomas H. Tvedten, M.D. is LRFPS's owner and medical director. LRFPS has been in existence since 1973. It is licensed by the State of Arkansas since the 1980s and is in good standing with the Arkansas Department of Health ("ADH"). LRFPS provides abortion care and related services. As Clinic Director, I oversee the day-to-day operation of LRFPS clinic. I

EXHIBIT 37

oversee all aspects of patient care under the supervision of Dr. Tvedten. In addition, I participate in all aspects of patient care as needed. I am responsible for management of patient records and all other records kept by LRFPS as mandated by the state and as needed to operate LRFPS. I am also responsible for LRFPS medical record keeping, financial management, and billing practices. In addition, I maintain a separate gynecological practice.

3. On May 16, 2016, LRFPS was inspected by ADH. At that time, the inspectors noted that LRFPS was charging patients seeking an abortion for the ultrasound and other services provided during her first visit prior to providing these services. ADH, however, found that LRFPS was in compliance with all its rules and regulations and did not cite LRFPS for violation of any law, including §20-16-1703(d). Attached as Exhibit A is a true and accurate copy of ADH's May 16, 2016, letter concerning its findings following the inspection. On July 14, 2016, ADH again inspected LRFPS. Following this inspection, ADH issued a Statement of Deficiencies citing violation of §20-16-1703(d) as the basis for a deficiency citation. After an appeal, ADH subsequently dismissed the citation, agreeing with LRFPS that ADH lacked authority to issue it because it had no authority over physician conduct and no rule or regulation covering the particular conduct involved. Attached as Exhibit B is a true and accurate copy of a letter from ADH's General Counsel Robert Brech dismissing the citation.

4. At LRFPS, during a patient's first visit, she is given information as required by law, and an ultrasound is performed by a certified sonographer. The ultrasound determines location of pregnancy (intrauterine or ectopic) whether the pregnancy is ongoing, the gestational age, and whether there is a fetal heartbeat. If an ectopic pregnancy is

suspected, the woman is referred on an urgent basis for additional care. If the pregnancy is not ongoing, the patient is offered miscarriage management or referral to the provider of her choice.

5. If the pregnancy is intrauterine and within the gestational range during which LRFPS provides abortions (21.6 weeks), and if the patient indicates she wishes to return to terminate her pregnancy, she is provided the information the state mandates that she receive in order to give informed consent 48 hours later. The informed consent is done by both a licensed nurse under the direction of a physician and a physician. All ultrasounds are interpreted by a physician using his education, training and experience to determine the patient's eligibility for an abortion and if eligible, to determine the best course of treatment for the patient.

6. The ultrasound is necessary at the first visit to comply with state-mandated requirements including 1) to determine whether there is a fetal heartbeat, and, if so, to inform the patient of that fact; 2) to inform the patient of how many weeks the pregnancy has advanced and of the probable anatomical and physiological characteristics of the embryo or fetus; and 3) to describe the method of the abortion the woman will obtain. State law mandates that the physician provide this information, which is dependent on an ultrasound, at least 48 hours before the abortion

7. But for Arkansas law, LRFPS would provide care all in one day for patients who request it: ultrasound, counseling and, abortion. The only reason to perform the ultrasound 48 hours in advance of an abortion is to comply with Arkansas's mandate that a woman receive certain information and then delay at least 48 hours before she may obtain an abortion. There is no medical reason why the ultrasound must be performed 48 hours in

3

advance of an abortion. However, because Arkansas mandates that delay, doing the ultrasound at the first visit reduces the risk that a patient will have to return unnecessarily - and suffer further delay -- if the ultrasound reveals that she is not eligible for an abortion at the LRFPS clinic. That occurs, for example, if her pregnancy has advanced beyond the point at which we provide abortions.

8. Prior to receiving the deficiency citation that is the subject of this administrative appeal, patients were charged $200 for the ultrasound and the other services provided at the first visit, and payment was required either by cash or credit card before the ultrasound was performed.

9. On January 30, 2018, ADH inspectors visited LRFPS; subsequently, ADH cited the clinic for violation of § 20-16-1703(d) for charging patients prior to the lapse of 48 hours after the first visit. The letter citing LRFPS was received March 14, 2018.

10. Since this latter date, LRFPS has ceased charging patients for the ultrasound described above at the first visit. If a women returns for an abortion, at that time she is charged either by credit card or cash for the amount of the ultrasound, the other initial services, and the abortion.

11. After receiving the services at their first visit, some women do not return to LRFPS for an abortion. This happens for a number of reasons. One common reason is that a woman cannot manage to travel back to our clinic: many of our patients struggle with poverty and have to travel from far away. Transportation, childcare, and work obligations are all problems. The state requirement that they make the trip twice to get an abortion is an insurmountable obstacle for some patients. Other women are beyond the point in

pregnancy at which we offer an abortion; if they are able to travel and desire a referral for abortion out of state, we provide such a referral.

12. If the woman does not return for an abortion within 30 days, LRFPS mails an invoice to the patient at the address she supplies at the first visit. The invoice requests immediate payment. If payment is not received within 30 days, a copy of the original is mailed again to the patient.

13. Based upon my experience, patients are often desperate to keep private their decision to inquire about an abortion. This is for a variety of reasons but often is because family members, including the woman's sexual partner, may have intensely negative feelings about abortion. Many women request that they be allowed to pay at the first visit.

14. LRFPS has considered contacting patients who do not return for an abortion by telephone to advise them that payment for the ultrasound and other services is due and to request payment in lieu of sending an invoice by mail. However, LRFPS staff has determined that the risk of invading patients' privacy by telephoning is greater than that of mailing an invoice. These risks include that someone other than the patient will answer the telephone and want to know from the patient the source and content of the call, or may overhear the patient speaking to us and glean information about the patient's visit to the clinic as a result.

15. I have concerns, based on my experience, that mailing a bill for the ultrasound to the patient's address does pose the risk that someone other than the patient will open the envelop and discover the visit to LRFPS. I have had experience with the privacy problems posed by mailing invoices. In one instance, I mailed an invoice to a patient and someone other than the patient called to inquire why the patient had visited the

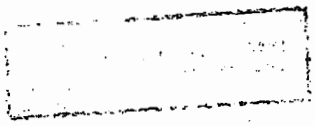
clinic. While I do believe that mailing a bill as opposed to telephoning a patient carries less risk of violating her privacy, both involve risks which can be avoided by permitting LRFPS to charge at the point services are provided.

16. Because of the same privacy concerns for abortion patients, LRFPS does not utilize the services of third-party collection services. This further limits our ability to obtain payment.

17. Since March 14, 2018, the day after receipt of the Statement of Deficiencies to the date of this affidavit, 108 patients, who did not return for an abortion, were billed. Of these six patients have paid for their ultrasound and other services after receiving a bill. This has resulted in a total loss of $20,000 to LRFPS and Dr. Tvedten over this period. This loss will increase so long as § 20-16-1703(d) is in effect.

18. In addition to the loss of revenue from patients, LRFPS incurs additional expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if § 20-16-1703(d) were not in effect as now interpreted by ADH. These additional expenses are $540 for 30 additional hours of staff time. These additional staff expenses will increase as long as this law is in effect. Thus, the total loss to LRFPS from March 14, 2018 to the date of this affidavit is $20,540.

19. Based on my experience as Clinic Director it is necessary to collect payment up front from patients as this is the only way to ensure payment for physician services rendered. In my experience, it is standard medical practice to charge at the time services are rendered unless they will be reimbursed by a third party.



Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

May 16, 2016

Lori Williams, Administrator
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

RE: Licensure Abortion Clinic Complaint Survey
Conducted 05/12/2016

Dear Ms. Williams:

Little Rock Family Planning Services, PLLC is considered to be in compliance with applicable provisions of the Rules and Regulations for Abortion Clinics in Arkansas. We appreciate the cooperation of the Facility staff during the survey.

If we may be of assistance at any time, please call (501) 661-2201.

Sincerely,

Liz Davis, Program Manager
Health Facility Services
Arkansas Department of Health

/sm

EXHIBIT
A
44 pages
Exh. 1

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204-1704 • Telephone (501) 661-2236
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

August 25, 2016

Ms. Bettina E. Brownstein, Attorney at Law
904 West Second Street
Little Rock, AR 72201

RE: Little Rock Family Planning/Dispute of Deficiency Finding

Dear Bettina:

Thank you for your August 17, 2016, letter disputing the deficiency citation issued to Little Rock Family Planning Services on August 5, 2016, in the Department's Statement of Deficiencies. You have made a number of legal arguments as to why the deficiency citation was improper. Specifically, the deficiency dealt with the facility accepting payments for services provided in relation to an abortion prior to the expiration of the forty-eight hour reflection period as required under Ark. Code Ann. § 20-16-1703(d).

I cannot disagree with your point that the Arkansas Department of Health lacks authority to issue this particular deficiency citation. I also agree that no Board of Health rule or regulation covers this particular conduct. Having determined that your first two points have merit, and my agreement that the Department lacked sufficient authority to issue the citation, I see no reason to address your additional legal arguments. I will instruct the Department staff to retract their deficiency citation. I do expect the staff will forward their findings to the State Medical Board for their consideration.

Sincerely,

Robert Brech, JD
General Counsel

RB/nc

cc: Connie Melton, Branch Chief, Health Systems Licensing
Renee Mallory, Center Director, Health Protection

EXHIBIT B
to
Exh. 1
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BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH — PETITIONER

V.

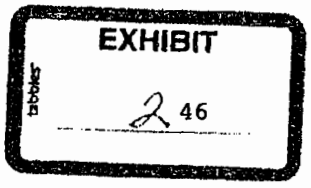
LITTLE ROCK FAMILY PLANNING SERVICES and

PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

Affidavit of Melany Helinski

My name is Melany Helinski. I am over the age of 21, competent and have personal knowledge of the matters testified to herein.

1. I am currently the Regional Director of Health Services at Planned Parenthood of Arkansas and Eastern Oklahoma ("PPAEO"). I have been Regional Director since 2013. As Regional Director of Health Services, I am responsible for all health and operational services at all PPAEO health centers in Oklahoma and Arkansas.
2. I submit this affidavit in support of PPAEO's appeal of the Statements of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 23, 2018 to PPAEO's Fayetteville Health Center and PPAEO's Little Rock Health Center, respectively. That statement was issued following letters dated March 13, 2018, in which ADH sought additional information about PPAEO's billing practices after an on-site inspection, and did not state whether a deficiency had been issued. ADH subsequently withdrew these initial letters and clarified that it considered PPAEO's practice, as described below, a deficiency in violation of state law.



3. I have worked in the health care field since 2001, when I began working at the Fairmount Center in Dallas, Texas, as a patient counselor for women seeking an abortion. At the Fairmount Center, I received training in all aspects of the process for patients to receive abortion care, including counseling, ultrasounds, and post-abortion laboratory procedures. I subsequently became counseling coordinator for the center. In 2007, I began working for Planned Parenthood Greater Texas as manager of its abortion facility in Dallas, Texas, where I remained until 2013. In 2013, I assumed my present position. PPAEO's Fayetteville and Little Rock health centers are licensed by the State of Arkansas and in good standing with the Arkansas Department of Health ("ADH").
4. As Regional Director of Health Services, my responsibilities are to provide direct supervision to all health center managers in my area, including the Fayetteville and Little Rock health centers. I monitor these health center's services, activities, and functions, including healthcare services, clerical services, scheduling, and finances. I also fill in if there are temporary staffing needs in the health centers. I monitor Fayetteville and Little Rock's health centers' billing procedures for all services performed by them. I am involved in setting policies and procedures to comply with all state and federal laws and ADH rules and regulations. I work with health center managers to ensure that all state-mandated information is both provided to patients and is documented to comply with all applicable laws and regulations.
5. All staff providing patient care at the Fayetteville and Little Rock health centers are supervised by a physician employed at that health center. In addition, PPAEO employs a Medical Director, who is a board-certified OBGYN and who is responsible for

developing and implementing all its medical policies and procedures utilized at the Fayetteville and Little Rock health centers.

6. The Fayetteville and Little Rock health centers provide medication abortions. During a patient's first visit, she is given written information in accordance with state law. She is provided information about both medication and surgical abortions, an ultrasound is performed by a nurse practitioner to determine whether the pregnancy is intrauterine and ongoing, how far the pregnancy has advanced, and whether there is embryonic or fetal cardiac activity. If an ectopic pregnancy is suspected, the women is referred on an urgent basis for additional care. If the pregnancy is not ongoing, the patient is offered miscarriage management or referral to the provider of her choice. If the pregnancy is intrauterine and within the period of pregnancy during which PPAEO provides abortion care (up to 10 weeks as dated from the first day of the woman's last menstrual period ("LMP")) and the patient indicates she wishes to return to terminate her pregnancy, she is provided the information the state mandates that she receive in order to give informed consent 48 hours later. Information required for informed consent is provided by both a licensed nurse under the direction of a physician and by a physician. All ultrasounds are interpreted by a physician using his or her education, training and experience to (1) determine the patient's pregnancy status, (2) guide the state's mandated information that must be communicated to the patient, e.g., how many weeks the pregnancy has advanced, and the type of procedure that will be used to terminate the pregnancy, and (3) determine the patient's plan of care, eligibility for an abortion and if eligible, to determine the best course of treatment for the patient.

7. The ultrasound is performed for multiple reasons: first, PPAEO's medical standards and guidelines require an ultrasound prior to medication abortion; second, the ultrasound is necessary to be able to comply with the state-mandated requirement to attempt to detect embryonic or fetal cardiac activity, and third, we use the ultrasound to determine how far along the pregnancy has advanced and - based on that – the probable characteristics of the embryo or fetus, which state law requires us to provide an abortion patient at least 48 hours before the abortion, together with a description of the type of procedure to be used. Thus, the ultrasound is performed during the woman's first visit more than 48 prior to a scheduled abortion because the information obtained by the ultrasound is required to be provided to her at least 48 hours before the abortion.

8. The only reason to perform the ultrasound 48 hours in advance of an abortion is to comply with Arkansas law. There is no medical reason why the ultrasound must be performed 48 hours in advance of an abortion. Given that state law requires two visits to obtain an abortion, having the ultrasound on the day one visit also reduces the risk that a woman will have to return unnecessarily if it is determined by ultrasound that the pregnancy is beyond 10 weeks LMP, making the patient ineligible for a medication abortion, which is the only type of abortion provided at PPAEO's Arkansas health centers.

9. Prior to the law that proscribes collecting payment until the expiration of 48 hours, PPAEO patients were charged at the first visit for the ultrasound, lab work (Rh factor, hemoglobin, and STD testing) and the state-mandated disclosures described above, and payment was required before the services were performed. The abortion procedure was charged separately at the second visit prior to it being performed.

10. After their first visit, some women do not return for an abortion. This happens for a number of reasons. One common reason is that a woman cannot manage to travel back to our health centers: many of our patients struggle with poverty and have to travel from far away. Transportation, childcare, and work obligations are all problems, especially for a large number of our patients who are poor and have to travel a long distance. The state requirement that they make the trip twice to get an abortion is hugely difficult for some patients. Since we only provide abortion through ten weeks LMP, other women are beyond the point in pregnancy at which we offer an abortion (or will be beyond this point by the time they can get back to our health centers); if they desire a referral for abortion to another provider who may offer an abortion for a longer period of pregnancy, we provide such a referral.

11. After § 20-16-1703(d) went into effect, PPAEO stopped charging for the day one visit until after expiration of the 48-hour period. PPAEO experienced a loss in revenue because of the delayed charging, and I participated in conversations around that time regarding ways to mitigate the financial losses experienced at the health centers; however, the exact data regarding financial losses experienced during that time is difficult to recreate because we merged our old record system with a new system in January 2017. In order to try to reduce its financial losses from being unable to charge for the day one services at the time of the day one visit, in February 2017, PPAEO began collecting credit card information at the first visit, but did not submit any charges for those patients who did not return for the second visit until the patient's gestation was out of range for a medication abortion. PPAEO did not submit charges less than 48 hours after the first visit in any circumstances. In the vast majority of cases, more than 48

hours passed, in order to see whether the patient would return for the abortion. In the overwhelming majority of cases, the credit card charges did not go through when PPAEO processed the credit card, and the patient was ultimately sent a paper bill. Since March 23, 2018, no money nor credit card information has been obtained prior to the lapse of 48 hours after the patient's first visit.

12. On January 25, 2018, ADH inspectors visited PPAEO's Little Rock Health Center to perform an inspection of our billing practices. They subsequently issued a letter, on March 13, 2018, seeking additional information about Little Rock Health Center's billing practice. Although the letter did not state that a deficiency or violation of § 20-16-1703(d) had been identified, the letter did state that PPAEO was required to appeal the violation (though none had been identified), submit a plan of correction, or have its licenses suspended. On February 1, 2018, ADH inspected the Fayetteville Health Center and ADH issued an identical letter requesting additional information about the Fayetteville Health Center's billing practices on March 13, 2018. Given the confusing language in these letters, PPAEO could not determine whether ADH believed that its practice of collecting credit card information complied with the statute.

13. Subsequently, on March 23, 2018, ADH issued new letters that withdrew its previous letters and explicitly cited both health centers for violation of § 20-16-1703(d) for charging patients for services provided at the first visit prior to the lapse of 48 hours.

14. Since March 23, 2018, PPAEO has ceased collecting credit card payment information for patients for the ultrasounds and other services provided at the first visit. If a women returns for an abortion, at that time she is charged either by credit card or cash for the services provided at the first visit and the abortion. If the woman does not return for an

related to their abortion. Similarly, some patients express concern when providing PPAEO with their address that nothing be mailed to their address. Other patients express a concern about being contacted by PPAEO about their abortion services by phone. Unfortunately, because of this law, we are unable to collect payment at the first visit even for those patients who affirmatively request to pay for the services at the first visit because of a desire to limit additional communications related their abortion services. Because of the same privacy concerns for abortion patients, PPAEO does not currently utilize the services of third-party collection services. This further limits our ability to obtain payment for the services we provided.

19. For those patients who affirmatively express concern about receiving mail related to their abortion, PPAEO will attempt to notify them about the outstanding balance through an alternative method, such as by phone. Contacting patients by phone about outstanding bills is challenging for multiple reasons: (1) some of our patients do not have working cell phones or land-line phones, or these numbers change frequently, which makes it difficult to contact them by phone; (2) some of our patients share cell phones or land-line phones with others, making it difficult for us to use this as a method of contacting patients about confidential medical services; and (3) we do not have the internal staff resources to follow up with these patients about outstanding bills by phone, particularly given that reaching a patient may take multiple attempts due to the factors detailed above. Thus, contacting these patients by phone (and indeed, any method of contacting patients after the fact to request payment for services provided) is both an unreliable way of

abortion, she receives a hard copy bill for these first visit services after the 48-hour period has run.

15. Based on my experience as Regional Director of Health Services for PPAEO and previous experience in abortion care provision, it is necessary to require payment from patients prior to providing services. This is the only way to ensure payment for physician and other professional services rendered. In my experience, it is standard medical practice to charge at the time services are rendered for services which will not be reimbursed by a third party.

16. I am unaware of any other medical provider who is prevented by the State of Arkansas from charging when a service is provided except in the case of emergency medical services

17. If a patient does not return for an abortion, the only way PPAEO can attempt to recover payment for the services provided at the first visit is to try to contact the patient in some fashion. PPAEO's practice of informing patients of outstanding balances is to send a paper invoice to the address on file. Since, absent this law, we always obtain payment for medical services from self-pay patients at the time of service, we send paper invoices out infrequently, but this will happen on occasion if a service that was supposed to be covered by insurance is not ultimately covered.

18. Based upon my experience, patients are often desperate to keep private their decision to inquire about an abortion. This can be for a variety of reasons but often is because family members, including the woman's sexual partner, may have intensely negative feelings about abortion. For that reason, some patients express concerns about PPAEO contacting them about their abortion services, and wish to limit any further contact from PPAEO

obtaining payment for the services we provided, and problematic for patient confidentiality as it poses a risk that this information will be disclosed.

20. In addition, I believe there are many additional patients who do not affirmatively state a concern with receiving mail at their address, but who nevertheless may be unable to keep their abortion confidential as a result of receiving a paper invoice for abortion-related services. I therefore have concerns, based on my experience, that contacting our patients after the fact to obtain payment for the ultrasound and other services poses a risk that a woman's abortion will be disclosed.

21. The same medical and other services are provided to patients irrespective of the timing of the request for payment for these services. Patients receive exactly the same information and receive the same informed consent counseling regardless of the timing of the payment for these services.

22. PPAEO relies on payment from its patients to funds the operation of its Fayetteville and Little Rock health centers and to cover the salaries of its doctors and staff.

FURTHER AFFIANT SAYETH NOT.

Melany Helinski

State of Oklahoma)
County of Tulsa)

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 1/12/22

Notary Public

ANDREW COLE AUKERMAN
NOTARY PUBLIC · STATE OF OKLAHOMA
MY COMMISSION EXPIRES JAN. 12, 2022
COMMISSION # 18000385

(Seal or Stamp)

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH — PETITIONER

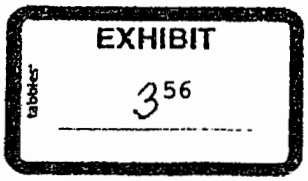
V.

LITTLE ROCK FAMILY PLANNING SERVICES AND PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

Affidavit of Nathan Johnson

My name is Nathan Johnson. I am over the age of 21, competent, and have personal knowledge of the matters attested to in this affidavit.

1. I am the Chief Financial Officer ("CFO") for Planned Parenthood of Arkansas and Eastern Oklahoma. I submit this affidavit on behalf of PPAEO in its appeal of the Statement of Deficiencies issued by the Arkansas Department of Health ("ADH") on March 23, 2018 to the PPAEO Fayetteville and Little Rock health centers.
2. As CFO, I am responsible for overseeing the collection, maintenance, and analysis of all financial records generated by the two health centers. In this capacity and in the ordinary course of business, I routinely gather data pertaining to the number of abortions performed at each health center, number of patients who were seen for ultrasounds and counseling, and other services (hereinafter "first day services"), and the timing, method, and amount of payments for services. To prepare this affidavit, I reviewed data stored in PPAEO's electronic health records system concerning patient visits and payments.
3. The PPAEO Fayetteville and Little Rock health centers have experienced significant loss of revenue as a result of § 20-16-1703(d)'s prohibition on obtaining payment for charges for ultrasounds and other medical services performed during a woman's first visit until



the expiration of 48 hours. Because we send out paper billings intermittently, we have not yet been able to ascertain the total lost revenue since we stopped collecting credit card information for first day services, as those patients have not yet had 30 days since receiving paper bills to remit payments.

4. From February 1, 2017 to March 22, 2018, PPAEO experienced a total loss of $10,961.66 in patient revenue from both health centers due to being unable to obtain payment for services provided to patients who had ultrasounds and/or other medical services, but did not subsequently obtain a medication abortion. A total of 57 women did not return for an abortion from February 1, 2017 to March 22, 2018, and had unpaid balances remaining on their accounts. This loss of fees occurred while PPAEO obtained credit card information from patients but did not process payment until the expiration of at least 48 hours. Due to the invalidity of the credit card numbers provided and the difficulty in recovering fees from these patients through paper bills, we still experienced a loss in revenue, and this loss will increase while the law's prohibition of payment at the point of service is in effect

5. Because we now do paper billing for patients who fail to return for second day services, we must invest additional resources into collecting outstanding charges. Previously, front office staff at the health centers could collect for those services at the same time they were checking in patients; now, we pay a revenue cycle vendor to handle billing for those services.

6. I have worked with the financial teams for other health care organizations, including large health care systems in Texas and Maryland. I had never heard of restrictions preventing providers from collecting for services provided on the date of service. In

limited cases, providers have agreed to accept subsequent insurance payments or allowed patients to establish payment plans. In either of those cases, of course, the decision not to require same-day payment was the result of a provider's choice to enter into a particular payment arrangement, not due to a state or federal requirement.

7. Based on my own experience working with the finances of multiple health care organizations, it is widely known that outstanding fees become increasingly more difficult to collect as more time passes from the date of service.

8. Patient revenue is crucial to PPAEO's ability to continue to operate both the Fayetteville and Little Rock Health Centers and to compensate the physicians and other professional staff for their services. The loss of revenue due to § 20-16-1703(d) is significant in terms of the Fayetteville and Little Rock health centers' ability to cover their operating expenses in the future.

FURTHER AFFIANT SAYETH NOT.

Nathan Johnson

State of Kansas)
County of Johnson)

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 8/17/2022

Leanne Mayer
Notary Public

LEANNE MAYER
My Appointment Expires
August 17, 2022

(Seal or Stamp)

Stricken language would be deleted from and underlined language would be added to present law.
Act 1086 of the Regular Session

State of Arkansas *As Engrossed: H3/23/15*
90th General Assembly **A Bill**
Regular Session, 2015 HOUSE BILL 1578

By: Representatives Lundstrum, Bentley, Copeland, Cozart, Davis, Dotson, Eads, C. Fite, Gates, M. Gray, Harris, Henderson, Lemons, D. Meeks, Miller, Payton, Petty, Rushing, B. Smith, Speaks, Sullivan, Vaught, Womack, *Ballinger, Brown, G. Hodges, J. Mayberry, Wallace*
By: Senators J. Hendren, B. Johnson, Files, Hester, *D. Sanders*

For An Act To Be Entitled

AN ACT TO REPEAL AND REPLACE THE WOMAN'S RIGHT TO KNOW ACT OF 2001; TO PROVIDE FOR VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION; TO PROVIDE PROCEDURES FOR ENSURING VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION; TO REQUIRE CERTAIN SIGNAGE IN ABORTION FACILITIES; TO PROVIDE FOR CERTAIN REQUIREMENTS OF THE DEPARTMENT OF HEALTH AND HOSPITALS RELATIVE TO ABORTION; TO PROVIDE FOR THE DELIVERY OF CERTAIN INFORMATION UNDER THE WOMAN'S RIGHT TO KNOW LAW; TO PROVIDE FOR PENALTIES; AND FOR OTHER PURPOSES.

Subtitle

TO REPEAL AND REPLACE THE WOMAN'S RIGHT TO KNOW ACT OF 2001; AND TO PROVIDE FOR VOLUNTARY AND INFORMED CONSENT FOR AN ABORTION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative findings and purposes.

(a) The General Assembly finds that:

(1) It is essential to the psychological and physical well-being of a woman who is considering an abortion that she receive complete and

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accurate information on abortion and its alternatives;

(2) The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two (2) alternatives: giving birth or having an abortion;

(3) Adequate and legitimate informed consent includes information which "relating to the consequences to the fetus," as stated in Planned Parenthood v. Casey, 505 U.S. 833, 882-883 (1992);

(4)(A) According to the Guttmacher Institute, in 2008 seventy percent (70%) of all abortions performed in the United States were performed in clinics devoted solely to providing abortions and family planning services.

(B) Most women who seek abortions at these facilities do not:

(i) Have any relationship with the physician who performs the abortion, before or after the procedure; or

(ii) Return to the facility for postsurgical care.

(C) In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision;

(5) The decision to abort a pregnancy is an important and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences, as stated in Planned Parenthood v. Danforth, 428 U.S. 52, 67 (1976);

(6) "The medical, emotional, and psychological consequences of an abortion are serious and can be lasting", as stated in H.L. v. Matheson, 450 U.S. 398, 411 (1981);

(7) Abortion facilities or providers often offer only limited or impersonal counseling opportunities; and

(8) Many abortion facilities or providers hire untrained and unprofessional counselors to provide preabortion counseling whose primary goal is actually to sell or promote abortion services.

(b) Based on the findings presented in subsection (a) of this section, the purposes of this act are to:

(1) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives and that every woman

receiving an abortion does so only after giving her voluntary and fully informed consent to the abortion procedure;

(2) Protect unborn children from a woman's uninformed decision to have an abortion;

(3) Reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed", as stated in Planned Parenthood v. Casey, 505 U.S. 833, 882 (1992); and

(4) Adopt the construction of the term "medical emergency" accepted by the United States Supreme Court in Planned Parenthood v. Casey, 505 U.S. 833 (1992).

SECTION 2. Arkansas Code Title 20, Chapter 16, is amended to add an additional subchapter to read as follows:

Subchapter 15 — Woman's Right-to-Know Act

20-16-1501. Title.

This subchapter shall be known and may be cited as the "Woman's Right-to-Know Act".

20-16-1502. Definitions.

As used in this subchapter:

(1)(A) "Abortion" means the act of using or prescribing any instrument, medicine, drug, or other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child.

(B) A use, prescription, or means under this subdivision (1) is not an abortion if the use, prescription, or means is performed with the intent to:

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

(ii) Remove a dead unborn child caused by spontaneous abortion; or

(iii) Remove an ectopic pregnancy;

(2)(A) "Abortion-inducing drug" means a medicine, drug, or any

other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child.

(B) "Abortion-inducing drugs" includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol, Cytotec, and methotrexate.

(C) This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications such as chemotherapeutic agents or diagnostic drugs.

(D) Use of drugs to induce abortion is also known as a medical, drug-induced, or chemical abortion;

(3) "Adverse event" means an undesirable experience associated with the use of a medical product in a patient, including without limitation an event that causes:

(A) Death;

(B) Threat to life;

(C) Hospitalization;

(D) Disability or permanent damage;

(E) Congenital anomaly or birth defect, or both;

(F) Required intervention to prevent permanent impairment or damage;

(G) Other serious important medical events, including without limitation:

(i) Allergic bronchospasm requiring treatment in an emergency room;

(ii) Serious blood dyscrasias;

(iii) Seizures or convulsions that do not result in hospitalization; and

(iv) The development of drug dependence or drug abuse;

(4) "Complication" means an adverse physical or psychological condition arising from the performance of an abortion, including without limitation:

(A) An adverse reaction to anesthesia or other

drugs;

(B) Bleeding;

(C) A blood clot;

(D) Cardiac arrest;

(E) Cervical perforation;

(F) Coma;

(G) Embolism;

(H) Endometritis;

(I) Failure to actually terminate the pregnancy;

(J) Free fluid in the abdomen;

(K) Hemorrhage;

(L) Incomplete abortion, also referred to as "retained tissue";

(M) Infection;

(N) Metabolic disorder;

(O) Undiagnosed ectopic pregnancy;

(P) Placenta previa in subsequent pregnancies;

(Q) Pelvic inflammatory disease;

(R) A psychological or emotional complication such as depression, anxiety, or a sleeping disorder;

(S) Preterm delivery in subsequent pregnancies;

(T) Renal failure;

(U) Respiratory arrest;

(V) Shock;

(W) Uterine perforation; and

(X) Other adverse event;

(5) "Conception" means the fusion of a human spermatozoon with a human ovum;

(6) "Emancipated minor" means a person under eighteen (18) years of age who is or has been married or who has been legally emancipated;

(7) "Facility" means a public or private hospital, clinic, center, medical school, medical training institution, healthcare facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location where medical care is provided to a person;

(8) "First trimester" means the first twelve (12) weeks of

gestation;

(9) "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period;

(10) "Hospital" means any institution licensed as a hospital pursuant to the laws of this state;

(11) "Medical emergency" means that condition which, on the basis of the physician's good-faith clinical judgment, complicates the medical condition of a pregnant woman and necessitates the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function;

(12) "Physician" means any person licensed to practice medicine in this state including medical doctors and doctors of osteopathy;

(13) "Pregnant" or "pregnancy" means that female reproductive condition of having an unborn child in the woman's uterus;

(14) "Qualified person" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, physician assistant, or physician;

(15) "Unborn child" means the offspring of human beings from conception until birth; and

(16) "Viability" means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of his or her mother, with or without artificial support.

20-16-1503. Informed consent requirement.

(a) A person shall not perform or induce an abortion without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced.

(b) Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

(1) At least forty-eight (48) hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

(A) The name of the physician who will perform the abortion;

(B) Medically accurate information that a reasonable patient would consider material to the decision concerning whether or not to undergo the abortion, including:

(i) A description of the proposed abortion method;

(ii) The immediate and long-term medical risks associated with the proposed abortion method, including without limitation the risks of:

(a) Cervical or uterine perforation;

(b) Danger to subsequent pregnancies;

(c) Hemorrhage; and

(d) Infection; and

(iii) Alternatives to the abortion;

(C) The probable gestational age of the unborn child at the time the abortion is to be performed;

(D) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(E) The medical risks associated with carrying the unborn child to term;

(F) Any need for anti-Rh immune globulin therapy if the woman is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy; and

(G) Information on reversing the effects of abortion-inducing drugs;

(2) At least forty-eight (48) hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person informs the woman, orally and in person, that:

(A) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her under § 20-16-1504;

(B) The printed materials and informational DVD under § 20-16-1504 describe the unborn child and list agencies that offer alternatives to abortion;

(C)(i) The father of the unborn child is liable to assist in the support of the child, even in instances where he has offered to pay for the abortion.

(ii) In a case of rape or incest, the information required under subdivision (b)(2)(C)(i) of this section may be omitted;

(D) The woman is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she otherwise might be entitled; and

(E) The information contained in the printed materials and informational DVD given to her under § 20-16-1504, is also available on a state website;

(3)(A) The information required under subdivisions (b)(1) and (2) of this section is provided to the woman individually and in a private room to protect her privacy, to maintain the confidentiality of her decision, to ensure that the information focuses on her individual circumstances, and to ensure that she has an adequate opportunity to ask questions.

(B) Subdivision (b)(3)(A) of this section does not preclude the provision of required information through a translator in a language understood by the woman;

(4)(A) At least forty-eight (48) hours before the abortion, the woman is given a copy of the printed materials and permitted to view and given a copy of the informational DVD under § 20-16-1504.

(B) If the woman is unable to read the materials, the materials shall be read to her in a language she can understand.

(C) If the woman asks questions concerning any of the information or materials under this subdivision (4), the person who provides or reads the information or materials shall answer her questions in a language she can understand;

(5)(A) At least forty-eight (48) hours before an abortion is performed or induced on a woman whose pregnancy has progressed to twenty (20) weeks gestation or more, the physician performing the abortion on the pregnant woman, the referring physician, or a qualified person assisting the physician shall, orally and in person, offers information on fetal pain to the patient.

(B) The information required under subdivision (b)(5)(A)

of this section and counseling related to that information shall include without limitation the following:

(i) That by twenty (20) weeks gestational age, the unborn child possesses all anatomical links in its nervous system, including spinal cord, nerve tracts, thalamus, and cortex, that are necessary in order to feel pain;

(ii) That an unborn child at twenty (20) weeks gestation or more is fully capable of experiencing pain;

(iii) A description of the actual steps in the abortion procedure to be performed or induced and at which steps in the abortion procedure the unborn child is capable of feeling pain;

(iv) That maternal anesthesia typically offers little pain prevention for the unborn child; and

(v) That an anesthetic, analgesic, or both are available so that pain to the fetus is minimized or alleviated;

(6)(A) Before the abortion, the pregnant woman certifies in writing on a checklist form provided or approved by the Department of Health that the information required under § 20-16-1504 has been provided.

(B) A physician who performs an abortion shall report monthly to the department the total number of certifications the physician has received.

(C) The department shall make available to the public annually the number of certifications received under subdivision (b)(6)(B) of this section;

(7)(A) Except in the case of a medical emergency, the physician who is to perform the abortion shall receive and sign a copy of the written certification required under subdivision (b)(6)(A) of this section before performing the abortion.

(B) The physician shall retain a copy of the checklist certification form in the pregnant woman's medical record; and

(8) At least forty-eight (48) hours before an abortion that is being performed or induced utilizing abortion-inducing drugs, the physician who is to perform the abortion, the referring physician, or a qualified person informs the pregnant woman, orally and in person, that:

(A) It may be possible to reverse the effects of the abortion if the pregnant woman changes her mind, but that time is of the

essence; and

(B) Information on reversing the effects of abortion-inducing drugs is available in materials prepared by the department.

(c)(1) In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion clearly certifies in writing the nature of the medical emergency and the circumstances that necessitated the waiving of the informed consent requirements under this subchapter.

(2) The certification required under subdivision (c)(1) of this section shall be signed by the physician who performed the emergency abortion and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion took place.

(d) A physician shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the *forty-eight-*hour reflection period required in this section.

(e) All ultrasound images, test results, and forms signed by the patient or legal guardian shall be retained as a part of the patient's medical record and be made available for inspection by the department or other authorized agency.

20-16-1504. Publication of materials.

(a)(1) The Department of Health shall:

(A) Publish easily comprehensible printed materials and an informational DVD in English and Spanish within ninety (90) days after the effective date of this subchapter;

(B) Develop and maintain a secure Internet website, which may be part of an existing website, to provide the information required under this subchapter; and

(C) Monitor the website on a weekly basis to prevent and correct tampering.

(2) The department shall not collect or maintain information regarding persons using the website.

(b) The department shall review and update annually, if necessary, the following printed materials and informational DVD which shall be easily

comprehensible:

(l)(A) Geographically indexed materials that inform a pregnant woman seeking an abortion of public and private agencies and services available to assist her through pregnancy, upon childbirth, and while her child is dependent, including without limitation adoption agencies.

(B) The materials shall:

(i) Include:

(a) A comprehensive list of the public and private agencies and services, a description of the services they offer, and the telephone numbers and addresses of the agencies; and

(b) The following statement: "There are many public and private agencies willing and able to help you to carry your child to term and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of Arkansas strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician or his or her agent give you the opportunity to call agencies like these before you undergo an abortion.";

(ii) Inform the pregnant woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care;

(iii) Contain a toll-free, twenty-four-hour telephone number that may be called to obtain information about the agencies in the geographic area of the caller and of the services offered; and

(iv) State that:

(a) It is unlawful for any individual to coerce a woman to undergo an abortion;

(b) If a minor is denied financial support by the minor's parents, guardian, or custodian due to the minor's refusal to undergo an abortion, the minor shall be deemed emancipated for the purposes of eligibility for public assistance benefits, except that benefits may not be used to obtain an abortion;

(c) A physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action; and

(d) The law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care.

(C) The department shall ensure that the materials described in this section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any public or private agency or service described in this section.

(2)(A) Materials that include information on the support obligations of a father of a child who is born alive, including without limitation the father's legal duty to support the child, including child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate, by a statement of paternity, or by court action.

(B) The materials shall state that more information concerning establishment of paternity and child support services and enforcement may be obtained by calling state or county public assistance agencies;

(3)(A) Materials that describe the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including color photographs of the unborn child at two-week gestational increments.

(B) The materials and descriptions shall:

(i)(a) Include information about brain and heart functions, the presence of external features and internal organs during the applicable stages of development, and any relevant information on the possibility of the unborn child's survival.

(b) If a photograph is not available, a picture shall contain the dimensions of the unborn child and shall be realistic; and

(ii) Be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages;

(4) Materials that contain objective information describing the various surgical and drug-induced methods of abortion, as well as the immediate and long-term medical risks commonly associated with each abortion method, including without limitation the risks of:

(A) Cervical or uterine perforation or rupture;

(B) Danger to subsequent pregnancies;

(C) Hemorrhage;

(D) Infection;

(E) Medical risks associated with carrying a child to term following an abortion; and

(F) Possible adverse psychological effects associated with an abortion;

(5) A uniform resource locator for the state website where the materials required under this section can be found;

(6) Materials that include information on the potential ability of a qualified person to reverse the effects of abortion-inducing drugs, such as mifepristone, Mifeprex, and misoprostol, including without limitation information directing a woman to obtain further information at appropriate websites and by contacting appropriate agencies for assistance in locating a healthcare professional to aide in the reversal of an abortion; and

(7) A checklist certification form to be used by the physician or a qualified person assisting the physician that lists the items of information to be given to the woman by a physician or the agent under this subchapter.

(c) The materials shall be printed in a typeface large enough to be clearly legible.

(d)(1) The department shall produce a standard format DVD that may be used statewide presenting the information required under this section.

(2) In preparing the DVD, the department may summarize and make reference to the comprehensive printed list of geographically indexed names and services described in this section.

(3)(A) The DVD shall show, in addition to the information described in this section, an ultrasound of the heartbeat of an unborn child at four to five (4-5) weeks gestational age, at six to eight (6-8) weeks gestational age, and each month thereafter, until viability.

(B) The information in the DVD shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

(e) The materials and the DVD required under this section shall be available at no cost from the department upon request and in appropriate number to any person, facility, or hospital.

20-16-1505. Prevention of forced abortion – Signage in abortion

facilities.

(a)(1) A licensed facility where abortions are performed shall post a sign conspicuously in a location defined in subsection (b) of this section that is clearly visible to all individuals who enter and that features the text contained in subdivision (a)(2) of this section.

(2) The sign shall display the following text:

"It is against the law for anyone, regardless of his or her relationship to you, to force you to have an abortion. You have the right to contact any local or state law enforcement or any social service agency to receive protection from any actual or threatened physical, emotional, or psychological abuse. It is against the law to perform, induce, prescribe for, or provide you with the means for an abortion without your voluntary consent.".

(b) The sign shall be posted in each waiting room, patient consultation room, and procedure room used by patients for whom abortions are performed, induced, prescribed or for whom the means for an abortion are provided.

(c) The continued posting of signage shall be a condition of licensure of any facility that performs or induces abortions.

(d) The display of signage does not discharge the duty of a facility to have a physician orally inform a pregnant woman of information and materials contained in § 20-16-1503.

(e)(1) The Department of Health shall provide all signs required by this section to the licensed abortion facility.

(2) The department may require that a licensed abortion facility reimburse the department for any costs associated with the sign or signs.

20-16-1506. Medical emergencies.

When a medical emergency compels the performance of an abortion, the physician shall inform the woman before the abortion, if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a *forty-eight-hour* delay will cause substantial and irreversible impairment of a major bodily function.

20-16-1507. Regulations — Collection and reporting of information.

(a) The Department of Health shall develop and promulgate regulations regarding reporting requirements.

(b)(1) The Arkansas Center for Health Statistics of the Department of Health shall ensure that all information collected by the center regarding abortions performed in this state shall be available to the public in printed form and on a twenty-four-hour basis on the center's website.

(2) In no case shall the privacy of a patient or doctor be compromised.

(c) The information collected by the center regarding abortions performed in this state shall be continually updated.

(d)(1)(A) By June 3 of each year, the department shall issue a public report providing statistics on the number of women who were provided information and materials pursuant to this subchapter during the previous calendar year.

(B) Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information received after the deadline.

(2) The department shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual who received information or materials in accordance with § 20-16-1503.

20-16-1508. Rules.

(a)(1) The Department of Health shall adopt rules to implement this subchapter.

(2) The department may add by rule additional examples of complications to supplement those in § 20-16-1503.

(c) The Arkansas State Medical Board shall promulgate rules to ensure that physicians who perform abortions, referring physicians, or agents of either physician comply with all the requirements of this subchapter.

20-16-1509. Criminal penalty.

A person who intentionally, knowingly, or recklessly violates this subchapter commits a Class A misdemeanor.

20-16-1510. Civil penalties.

(a) In addition to any remedies available under the common law or statutory law of this state, failure to comply with the requirements of this subchapter shall provide a basis for a:

(1) Civil malpractice action for actual and punitive damages; and

(2) Professional disciplinary action under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(b) A civil liability shall not be assessed against the woman upon whom the abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close the proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed or attempted.

(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fee in favor of the defendant against the plaintiff.

20-16-1511. Construction.

(a) This subchapter does not create or recognize a right to abortion.

(b) This subchapter is not intended to make lawful an abortion that is currently unlawful.

SECTION 3. Arkansas Code Title 20, Chapter 16, Subchapter 9, is repealed.

~~Subchapter 9 — Woman's Right to Know Act of 2001~~

~~20-16-901. Title.~~

~~This subchapter shall be known and may be cited as the "Woman's Right to Know Act of 2001".~~

~~20-16-902. Definitions.~~

~~As used in this subchapter:~~

~~(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant, for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after a live birth, or to remove a dead fetus;~~

~~(2) "Attempt to perform an abortion" means an act or an omission of a statutorily required act that under the circumstances as the actor believes them to be constitutes a substantial step in a course of conduct planned to culminate in the termination of a pregnancy in Arkansas;~~

~~(3) "Board" means the Arkansas State Medical Board or the appropriate health care professional licensing board;~~

~~(4) "Division" means the Department of Health;~~

~~(5) "Director" means the Director of the Department of Health;~~

~~(6) "Gestational age" means the age of the fetus as calculated from the first day of the last menstrual period of the pregnant woman;~~

~~(7) "Medical emergency" means any condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of impairment of a major bodily function which is substantial and deemed to be irreversible;~~

~~(8) "Physician" means any person licensed to practice medicine in this state; and~~

~~(9) "Probable gestational age of the fetus" means what in the judgment of the physician will with reasonable probability be the gestational age of the fetus at the time the abortion is planned to be performed.~~

~~20-16-903. Informed consent.~~

~~(a) No abortion shall be performed in this state except with the voluntary and informed consent of the woman upon whom the abortion is to be performed.~~

~~(b) Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:~~

~~(1)(A) Before and in no event on the same day as the abortion, the woman is told the following by telephone or in person by the physician~~

~~who is to perform the abortion, by a referring physician, or by an agent of either physician:~~

~~(i) The name of the physician who will perform the abortion;~~

~~(ii) The medical risks associated with the particular abortion procedure to be employed;~~

~~(iii) The probable gestational age of the fetus at the time the abortion is to be performed;~~

~~(iv) The medical risks associated with carrying the fetus to term; and~~

~~(v) That a spouse, boyfriend, parent, friend, or other person cannot force her to have an abortion.~~

~~(B) The information required by this subdivision (b)(1):~~

~~(i) Shall be provided during a consultation in which the physician or his or her agent is able to ask questions of the woman and the woman is able to ask questions of the physician;~~

~~(ii)(a) May be provided by telephone without conducting a physical examination or tests on the woman.~~

~~(b) If the information is supplied by telephone, the information may be based both on facts supplied to the physician or his or her agent by the woman and on whatever other relevant information is reasonably available to the physician or his or her agent; and~~

~~(iii) Shall not be provided by a tape recording.~~

~~(C) If a physical examination, tests, or other new information subsequently indicates the need in the medical judgment of the physician for a revision of the information previously supplied to the woman, that revised information may be communicated to the woman at any time before the performance of the abortion.~~

~~(D) This section does not preclude the provision of required information through a translator in a language understood by the woman;~~

~~(2)(A) Before and in no event on the same day as the abortion, the woman is informed by telephone or in person by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician:~~

~~(i) That medical assistance benefits may be~~

~~available for prenatal care, childbirth, and neonatal care;~~

~~(ii) That the father is liable to assist in the support of her child, even in instances in which the father has offered to pay for the abortion;~~

~~(iii) That she has the option to review the printed or electronic materials described in § 20-16-904 and that those materials:~~

~~(a) Have been provided by the state; and~~

~~(b) Describe the fetus and list agencies that offer alternatives to abortion; and~~

~~(iv) That if the woman chooses to exercise her option to view the materials:~~

~~(a) In a printed form, the materials shall be mailed to her by a method chosen by her; or~~

~~(b) Via the Internet, she shall be informed before and in no event on the same day as the abortion of the specific address of the website where the materials can be accessed.~~

~~(B) The information required by this subdivision (b)(2) may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to review the printed materials;~~

~~(3) Before the abortion, the woman certifies in writing that the information described in subdivision (b)(1) of this section and her options described in subdivision (b)(2) of this section have been furnished to her and that she has been informed of her option to review the information referred to in subdivision (b)(2)(A)(iii) of this section;~~

~~(4) Before the abortion, the physician who is to perform the procedure or the physician's agent receives a copy of the written certification prescribed by subdivision (b)(3) of this section; and~~

~~(5) Before the abortion, the physician confirms with the patient that she has received information regarding:~~

~~(A) The medical risks associated with the particular abortion procedure to be employed;~~

~~(B) The probable gestational age of the fetus at the time the abortion is to be performed;~~

~~(C) The medical risks associated with carrying the fetus to term; and~~

~~(D) That a spouse, boyfriend, parent, friend, or other person cannot force her to have an abortion.~~

~~(c) The Arkansas State Medical Board shall promulgate regulations to ensure that physicians who perform abortions, referring physicians, or agents of either physician comply with all the requirements of this section.~~

~~20-16-904. Printed materials.~~

~~(a) The Department of Health shall cause to be published in English and in each language which is the primary language of two percent (2%) or more of the state's population and shall update on an annual basis the following printed materials in such a way as to ensure that the information is easily comprehensible:~~

~~(1) At the option of the department:~~

~~(A) Geographically indexed materials designed to inform the woman of public and private agencies, including adoption agencies, and services available to assist a woman through pregnancy, upon childbirth, and while the child is dependent, including:~~

~~(i) A comprehensive list of the agencies available;~~

~~(ii) A description of the services they offer; and~~

~~(iii) A description of the manner, including telephone numbers, in which they might be contacted; or~~

~~(B) Printed materials, including a toll-free telephone number which may be called twenty-four (24) hours per day to obtain orally a list and description of agencies in the locality of the caller and of the services they offer; and~~

~~(2)(A) Materials designed to inform the woman of the probable anatomical and physiological characteristics of the fetus at two-week gestational increments from the time when a woman can be known to be pregnant to full term, including:~~

~~(i) Any relevant information on the possibility of the fetus' survival; and~~

~~(ii) Pictures or drawings representing the development of fetuses at two-week gestational increments, provided that the pictures or drawings shall describe the dimensions of the fetus and shall be realistic and appropriate for the stage of pregnancy depicted.~~

~~(B) The materials shall be objective, nonjudgmental, and~~

~~designed to convey only accurate scientific information about the fetus at the various gestational ages.~~

~~(C) The material shall also contain objective information describing:~~

~~(i) The methods of termination of pregnancy procedures commonly employed;~~

~~(ii) The medical risks commonly associated with each of those procedures;~~

~~(iii) The possible detrimental psychological effects of termination of pregnancy; and~~

~~(iv) The medical risks commonly associated with carrying a child to term.~~

~~(b) The materials referred to in subsection (a) of this section shall be printed in a typeface large enough to be clearly legible.~~

~~(c) The materials required under this section shall be available at no cost from the department and shall be distributed upon request in appropriate numbers to any person, facility, or hospital.~~

~~(d)(1) The department shall develop and maintain a secure website to provide the information described under subsection (a) of this section.~~

~~(2) The website shall be maintained at a minimum resolution of seventy-two pixels per inch (72 ppi).~~

~~20-16-905. Procedure in case of medical emergency.~~

~~When a medical emergency compels the performance of an abortion, the physician shall inform the woman, prior to the abortion if possible, of the medical indications supporting the physician's judgment that:~~

~~(1) An abortion is necessary to avert her death; or~~

~~(2) A delay will create a serious risk of impairment of a major bodily function which is substantial and deemed to be irreversible.~~

~~20-16-906. Regulations -- Collection and reporting of information.~~

~~(a) The Department of Health shall develop and promulgate regulations regarding reporting requirements.~~

~~(b) The Arkansas Center for Health Statistics of the Department of Health shall ensure that all information collected by the center regarding abortions performed in this state shall be available to the public in printed~~

~~form and on a twenty-four hour basis on the center's website, provided that in no case shall the privacy of a patient or doctor be compromised.~~

~~(c) The information collected by the center regarding abortions performed in this state shall be continually updated.~~

~~(d)(1)(A) By June 3 of each year, the department shall issue a public report providing statistics on the number of women provided information and materials pursuant to this subchapter during the previous calendar year.~~

~~(B) Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information received after the deadline.~~

~~(2) The department shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual who received information in accordance with § 20-16-903.~~

~~20-16-907. Penalties.~~

~~(a) A person who knowingly or recklessly performs or attempts to perform a termination of a pregnancy in violation of this subchapter shall be subject to disciplinary action by the Arkansas State Medical Board.~~

~~(b) No penalty may be assessed against the woman upon whom the abortion is performed or attempted to be performed.~~

~~(c) No penalty or civil liability may be assessed for failure to comply with any provision of § 20-16-903 unless the Department of Health has made the printed materials available at the time that the physician or the physician's agent is required to inform the woman of her right to review them.~~

~~20-16-908. Woman's anonymity.~~

~~(a) In every proceeding or action brought under this subchapter, the court or board shall rule, upon motion or sua sponte, whether the identity of any woman upon whom a termination of pregnancy has been performed or attempted shall be preserved from public disclosure if she does not give her consent to disclosure.~~

~~(b) If the court or board rules that the woman's anonymity should be preserved, the court or board shall order the parties, witnesses, and counsel to preserve her anonymity and shall direct the sealing of the record and the~~

~~exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure.~~

~~(c) Each order to preserve the woman's anonymity shall be accompanied by specific written findings explaining:~~

~~(1) Why the anonymity of the woman should be preserved from public disclosure;~~

~~(2) Why the order is essential to that end;~~

~~(3) How the order is narrowly tailored to serve that interest; and~~

~~(4) Why no reasonable less restrictive alternative exists.~~

~~(d) This section shall not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.~~

SECTION 4. DO NOT CODIFY. The enactment and adoption of this act shall be in conjunction with and not supersede the Arkansas Human Heartbeat *Protection Act, § 20-16-1301 et seq., derived from Acts 2013, No. 301.*

SECTION 5. DO NOT CODIFY. SAVINGS CLAUSE. If any section or part of a section of this act is determined by a court to be unconstitutional, the Woman's Right to Know Act of 2001, § 20-16-901 et seq., shall be revived, and to prevent a hiatus in the law, the relevant section or part of a section of the Woman's Right to Know Act of 2001 shall remain in full force and effect from and after the effective date of this act notwithstanding its repeal by this act.

/s/Lundstrum

APPROVED: 04/06/2015

BEFORE THE ARKANSAS BOARD OF HEALTH

ADH Brief in Support of Deficiency Findings
and Response to Motion to Dismiss

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH — PETITIONER

v.

LITTLE ROCK FAMILY PLANNING SERVICES and
PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA
d/b/a PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

BACKGROUND

The facts giving rise to this matter are not in dispute. In 2015, "The Woman's Right to Know Act" ("the Act") was passed.[1,2] In pertinent part, the Act required certain information to be provided to a woman at least 48 hours before aborting a fetus ("reflection period"). The Act also prohibited a **physician** from requiring or obtaining payment for abortion-related services until after the 48-hour reflection period ("payment delay").[3] On or about August 5, 2016, petitioner Arkansas Department of Health ("ADH") issued a deficiency citation to respondent Little Rock Family Planning Services (LRFPS) for violating the payment delay by failing to prohibit collecting such fees. However, upon LRFPS' objection, ADH retracted the citation agreeing that ADH and the Board of Health lacked authority over physician billing and that no Board of Health rule covered the offending conduct.[4]

In 2017, the Act was amended to include facilities, employees, volunteers, or any other person or entity[5] (along with physicians) as those bound by the payment delay.

In March 2018,[6,7] ADH investigated a complaint that the three respondent facilities were noncompliant with the payment delay. ADH found the complaint to be substantiated and cited the respondents for deficiencies under A.C.A. 20-16-1703(d)[8]. (Petitioner Exhibit 1) From the citations, Respondents appeal.

---

[1] Act 1086 of 2015, codified at A.C.A. 20-16-1701 through 17011, attached as Exhibit 4 to Respondents Brief.
[2] Repealing a 2001 Act by the same name
[3] A.C.A. 20-16-1703(d)
[4] See Respondent's Exhibit B to Exhibit 1
[5] Act 383 of 2017
[6] March 13 to Little Rock Family Planning Services
[7] March 23 to Planned Parenthood Fayetteville and Planned Parenthood Little Rock
[8] *A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight- hour reflection period required in this section.*

ADH and Respondents have agreed to submit the matter to this Board for determination on written briefs. In order to preserve certain constitutional questions for future appeal, the issues are necessarily included in the Brief submitted by Respondents, along with tort claims. Because an administrative agency does not have authority to determine the constitutionality of a statute[9] and there is a presumption of constitutionality of a statute[10], ADH has not included those constitutional arguments in this Brief.

ISSUES BEFORE THE ARKANSAS BOARD OF HEALTH

1. ADH is authorized to investigate the subject matter of the complaint and did not exceed its authority.

a. Licensing and regulatory authority – A.C.A. 20-9-302

ADH is authorized and required by A.C.A. 20-9-302 ("licensing authority statute") to license and inspect abortion facilities, among other things. Petitioner Exhibit 2

Sections (a) and (b) read as follows:

> *(a) (1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted in any month, including nonsurgical abortions,* ***shall be licensed by the Department of Health.***
>
> *(2) (A)* ***The department shall inspect*** *a clinic, health center, or other facility at least annually, and inspections shall include without limitation:*
>
> *(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and*
>
> *(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.*
>
> *(B) An* ***inspector shall arrive at the clinic****, health center, or other facility unannounced and without prior notice.*
>
> *(b) The department shall:*

[9] *Teston v. Arkansas State Board of Chiropractic Examiners*, 361 Ark. 300 (2005).
[10] *Bayer CropScience LP v. Shafer*, 2011 Ark. 518

> *(1) Adopt appropriate rules, including without limitation the facilities, equipment,* ***procedures****, techniques, medical records,* ***informed consent signatures****, parental consent signatures, and conditions of clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:*
>
> > *(A) The facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard; and*
> >
> > *(B) The medical records,* ***informed consent signatures****, and parental consent signatures* ***meet statutory requirements****;* (emphasis added)

Thus, ADH is to license, inspect, and adopt appropriate rules[11] to assure that health standards and statutory requirements are met. The statutory language is clear and unequivocal that ADH has both the authority and responsibility to inspect Respondents licensed facilities and to assure that the facilities meet statutory requirements (including informed consent signatures).

ADH has adopted and continues the promulgation of appropriate rules pursuant to the licensing authority statute. A copy of the *Rules and Regulations for Abortion Facilities in Arkansas* ("Rules") is attached hereto as Petitioner's Exhibit 3.

b. Payment delay is a component of "informed consent"

When the payment delay was extended in 2017 to apply to facilities, the amending language made clear that such payment delay is part of the informed consent requirements which must precede an abortion in Arkansas. Section 3 of Act 383 of 2017 states in its entirety:

> *SECTION 3. Arkansas Code § 20-16-1703(d),* ***concerning the informed consent requirement*** *within the Woman's Right-to-Know Act, is amended to read as follows:*
>
> > *(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section.* (bold emphasis added)

[11] ADH administers rules adopted by the Arkansas State Board of Health

c. Licensing authority statute directs ADH to enforce informed consent signature requirements – no additional rule is required

As discussed in paragraph (a), the licensing authority statute directs ADH to inspect abortion facilities and to assure that the facilities meet statutory requirements (including informed consent signatures). Payment delay is part of an overall 48-hour reflection period through which valid informed consent is obtained. The reflection period allows for due consideration of the abortion based on information provided at the time of inquiry. As such, signatures obtained for payment delay purposes are among the informed consent signatures that ADH is statutorily directed to review, with an end to assure statutory requirements are met. No additional rule is necessary for ADH to accomplish this express duty.

d. Informed consent requirement statute makes the 48-hour reflection period applicable to Respondent's facilities – a rule unnecessary

When enacted in 2015, payment delay language specified that "a physician" shall not require or obtain payment until after the reflection period. In 2017, the payment delay (A.C.A. 20-16-1703(d)) was amended[12] to also expressly include "facilities, employees, volunteers, or any other person or entity." A copy of the amending act (Act 383 of 2017) is attached as Petitioner's Exhibit 3 showing the change in strike-through format. Arkansas has long required a liberal construction of such remedial legislation. *Chicago Mill & Lumber Co. v. Smith*, 228 Ark. 876 (1958). By its plain language, the payment delay applies to facilities under regulatory authority of ADH.

e. Where a rule is unnecessary, its absence is wholly appropriate

A.C.A. 20-16-1703(d) is clear that a facility *shall not require or obtain payment* until the 48-hour reflection period has passed. A rule is unnecessary to give effect to such plain and unequivocal language. The absence of an ADH rule is therefore appropriate under the licensing authority statute, A.C.A. 20-9-302(b)(1), which specifies that ADH is to adopt *appropriate* rules.

f. Informed consent requirement statute makes all signed forms available to ADH – no additional rule is required

A.C.A. 20-16-1703(e) declares that "all ultra sound images, test results, and **forms signed by the patient** or legal guardian shall be retained as a part of the patient's medical record and be made available for inspection by the department or other authorized agency." The basic rule of statutory construction is to give effect to the legislative intent and when the language is plain and unambiguous the statue is construed by giving ordinary and usually accepted meaning in common language. *See Ozark Gas Pipeline Corp. v. Ark. Public Service Commission*, 342 Ark. 591 (2000). The plain language of the statue requires that any document(s) signed with respect to payment agreements during the payment delay must be kept and made available to ADH.

[12] Section 3, page 4, L. 36; page 5

2. **ADH was not acting in an arbitrary or capricious manner by issuing a deficiency citation based on the 2017 change in the law.**

As previously outlined in this Petition, ADH had withdrawn a deficiency finding in 2016 based on the law that was in place at that time in which the restriction against requiring or obtaining payment until after a 48-hour reflection period was applicable only to "a physician". However, in 2017 law was amended. The amendment expanded application to include a "facility, employee or volunteer of a facility or any other person or entity." The legislative remediation easily distinguishes the current citation(s) from the one withdrawn in 2016. ADH citations, findings, letters, and transactions in 2016 under prior law are inapplicable to the current citations under the amended law.

3. **ADH was not acting in an arbitrary and capricious manner by issuing a deficiency citation for the collection of credit card information with the 48 hour period.**

A mere delay is not a taking, particularly where the delay is imposed for valid public policy reasons. One such example is healthcare services provided to employees injured on the job. Providers are restricted from billing injured employees who suffer work-related injuries once the provider has notice. A.C.A.11-9-118.

In *Arkansas State Police Comm'n v. Smith*, 338 Ark. 354 (1999)3, the court ruled that an administrative action may not be regarded as arbitrary and capricious unless it is not supportable on any rational basis. In order to have any action set aside as arbitrary and capricious, the challenging party must show that the action was willful and unreasoning, without consideration, and with a disregard of the facts or circumstances. *Id.* Respondents have presented no valid argument that ADH's conduct rose to this standard.

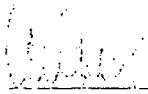
4. **By following state law, there has been no action constituting tortious interference with contract.**

ADH has not acted in an arbitrary and capricious manner in following the state statute. Moreover, sovereign immunity precludes a claim for tortious interference with contract and the Respondents have failed to assert a fact that would preclude applying the doctrine of sovereign immunity. *See Milligan v. Burrow*, 52 Ark. App. 20, (1996)

Conclusion

The Petitioner respectfully requests that the Arkansas Board of Health uphold the deficiency citations that were issued.

Respectfully submitted,



Ann Purvis, J.D.
Arkansas Bar License 88153
Deputy Director for Administration
4815 West Markham
Little Rock, AR 72205
501-280-4545

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

March 13, 2018

[redacted]
Planned Parenthood of Arkansas and Eastern Oklahoma
3729 North Crossover, Suite 107
Fayetteville, AR 72703

Re: Complaint Investigation 02/01/18

Dear [redacted]

On February 1, 2018, the Arkansas Department of Health conducted a complaint investigation at your facility. Based on document review and confirmation by interviews, it was determined the facility has possibly been requiring or obtaining payment for services provided in relation to abortion before the expiration of the forty-eight-hour reflection period, in violation of Ark. Code Ann. § 20-16-1703(d). To further assist our investigation, we ask that you provide the following information:

- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by credit or debit card.
- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by cash.
- Describe the steps and timing by which the facility obtains payment from patients who inquire about or schedule an abortion and who pay by any means other than credit card, debit card, or cash.

Pursuant to Arkansas Ann Code §20-9-302 (3)(A)(ii) you have thirty (30) days from the mailing of this notice to submit your plan for correction of the violation or ask for a hearing. If you fail to do so, the license will be suspended. The suspension shall remain in effect until all violations have been corrected pursuant to §20-9-302 (3)(A)(iv).

Sincerely,

Becky Bennett

Becky Bennett, Section Chief
Health Facility Services
Phone: 501-661-2201

Petitioner Exhibit 1

Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

March 13, 2018

[redacted]
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

Re: Complaint Investigation 01/30/18

Dear [redacted].

On January 30, 2018, the Arkansas Department of Health conducted a complaint investigation at your facility. Based on document review and confirmation by interviews, it was determined your facility has been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight-hour reflection period, in violation of Ark. Code Ann. § 20-16-1703(d).

Pursuant to Arkansas Ann Code §20-9-302 (3)(A)(ii) you have thirty (30) days from the mailing of this notice to submit your plan for correction or ask for a hearing. If you fail to do so, the license will be suspended. The suspension shall remain in effect until all violations have been corrected pursuant to §20-9-302 (3) (A)(iv).

Sincerely,

Becky Bennett

Becky Bennett Section Chief
Health Facility Services
Phone: 501-661-2201

20-9-302. Abortion clinics, health centers, etc.

(a)

(1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted in any month, including nonsurgical abortions, shall be licensed by the Department of Health.

(2) (A) The department shall inspect a clinic, health center, or other facility at least annually, and inspections shall include without limitation:

(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and

(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.

(B) An inspector shall arrive at the clinic, health center, or other facility unannounced and without prior notice.

(b) The department shall:

(1) Adopt appropriate rules, including without limitation the facilities, equipment, procedures, techniques, medical records, informed consent signatures, parental consent signatures, and conditions of clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:

(A) The facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard; and

(B) The medical records, informed consent signatures, and parental consent signatures meet statutory requirements;

(2) Levy and collect an annual fee of five hundred dollars ($500) per facility for issuance of a permanent license to an abortion facility; and

(3) (A) Deny, suspend, or revoke licenses on any of the following grounds:

(i) The violation of any provision of law or rule; or

(ii) The permitting, aiding, or abetting of the commission of any unlawful act in connection with the operation of the institutions.

(B)

(i) If the department determines to deny, suspend, or revoke a license, the department shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(ii) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(iii) ***(a)*** The department shall issue an immediate suspension of a license if an investigation or survey determines that:

(1) The applicant or licensee is in violation of any state law, rule, or regulation; and

Petitioner Exhibit 2

(2) The violation or violations pose an imminent threat to the health, welfare, or safety of a patient.

(b)

(1) The department shall give the applicant or licensee written notice of the immediate suspension.

(2) The suspension of the license is effective upon the receipt of the written notice.

(iv) The denial, suspension, or revocation order shall remain in effect until all violations have been corrected.

(C) The applicant or licensee shall:

(i) Be given a fair hearing; and

(ii) Have the right to present evidence as may be proper.

(D)

(i) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(ii) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

(iii) The decision shall become final fifteen (15) days after it is mailed unless the applicant or licensee, within the fifteen-day period, appeals the decision to the court.

(E) A full and complete record of all proceedings shall be kept and all testimony shall be reported, but it need not be transcribed unless the decision is appealed or a transcript is requested by an interested party who shall pay the cost of preparing the transcript.

(F) Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by rule.

(G) The procedure governing hearings authorized by this section shall be in accordance with rules promulgated by the department.

(c)

(1) Applicants for a license shall file applications upon such forms as are prescribed by the department.

(2) A license shall be issued only for the premises and persons in the application and shall not be transferable.

(d)

(1) A license shall be effective on a calendar-year basis and shall expire on December 31 of each calendar year.

(2) Applications for annual license renewal shall be postmarked no later than January 2 of the succeeding calendar year.

(3) License applications for existing institutions received after that date shall be subject to a penalty of two dollars ($2.00) per day for each day after January 2.

(e) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the abortion clinics that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

(f) All fees levied and collected under this section are special revenues and shall be deposited into the State Treasury to be credited to the Public Health Fund.

Agency # 007.05

RULES AND REGULATIONS FOR ABORTION FACILITIES IN ARKANSAS

ARKANSAS DEPARTMENT OF HEALTH
2017

Petitioner Exhibit 3

Rules and Regulations For Abortion Facilities 2014

Rules and Regulations For Abortion Facilities 2014

SECTION 1. PREFACE.

These Rules and Regulations have been prepared for the purpose of establishing criteria for minimum standards for licensure, operation and maintenance of Abortion Facilities. By necessity they are of a regulatory nature but are considered to be practical minimum design and operational standards for their facility type. These standards are not static and are subject to periodic revisions. It is expected Abortion Facilities will exceed these minimum requirements and will not be dependent upon future revisions as a necessary prerequisite for improved services.

Rules and Regulations For Abortion Facilities 2014

SECTION 2. AUTHORITY.

These Rules and Regulations for Abortion Facilities in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Acts 509 of 1983 and 1176 of 2011; Ark. Code Ann. § 20-9-302 as amended.

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SECTION 3. DEFINITIONS.

Note: see Section 12 for additional definitions for Physical Facilities requirements

A. **Abortion** - the use or prescription of any instrument, medicine, drug, or any other substance or device:

1. To terminate the pregnancy of a woman known to be pregnant with an intention other than to:
   a. Increase the probability of a live birth;
   b. Preserve the life or health of the child after live birth; or
   c. to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and

2. Which causes the premature termination of the pregnancy.

Note: Abortions are prohibited during and after the twentieth (20th) week of a woman's pregnancy except as authorized by law. See Ark. Code Ann. § 20-16-1401 et seq.

B **Abortion Facility** - A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted each month, including non-surgical abortions.

C. **Act** - Act 509 of 1983 as amended by Act 1176 of 2011

D **Administrator** - an individual designated to provide daily supervision and administration of the Abortion Facility.

E. **Consent** - a signed and witnessed voluntary agreement for the performance of an abortion.

F. **Dead fetus or fetal remains** - a product of human conception exclusive of the placenta or connective tissue, which has suffered death prior to the complete expulsion or extraction from the mother as established by the fact that, after the expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

G **Department** - the Arkansas Department of Health.

H. **Division** - the Division of Health Facility Services.

I. **Director** - the Chief Administrative Officer in the Division of Health Facility Services.

J **General Abortion Facility** - an abortion facility that provides surgical abortions or both medical and surgical abortions.

K. **Hospital** - Any acute care facility established for the purpose of providing inpatient diagnostic care and treatment.

L. **Local Anesthesia** – Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug.

M. **Medical abortion** - a non-surgical abortion for which abortifacient pharmaceutical drugs are used to induce the abortion.

N **Medical-Only Abortion Facility** - an abortion facility in which no surgical abortions are performed.

O. **Minimal Sedation (Anoxiolysis)** – a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected.

P. **Moderate Sedation/Analgesia ("Conscious Sedation")** – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate.

Q. **Patient** - any woman receiving services in the facility.

R. **Surgical abortion** means a pregnancy is ended by surgically removing the contents of the uterus through use of suction device or other instrument(s).

SECTION 4. LICENSING.

A. Application for License. Application for a license or renewal of a license shall be made on forms provided by the Arkansas Department of Health. The application shall set forth:

1. The complete name and address of the Abortion Facility

2. The facility type:

(a) General Abortion Facility; or

(b) Medical-Only Abortion Facility; and

3. Additional information as required by the Arkansas Department of Health.

B. Grandfather provisions.

1. A facility, in existence on January 1, 2012 and in substantial compliance with the physical facility requirements in Section 12, submitting initial application for licensure by July 1, 2012 is exempted from the physical facility requirements in Section 12 of these Rules for its existing physical structure. Notwithstanding this provision, a facility must be in compliance with these rules after January 1, 2014, unless the modifications would be impracticable.

2. Except as otherwise provided in Section (4)(B)(1), Abortion Facilities shall comply with all requirements set forth in these Rules and Regulations. The Rules and Regulations shall become effective on January 1, 2012.

C Availability of Emergency Services. A General Abortion Facility shall be within thirty (30) minutes of a hospital which provides gynecological or surgical services.

D. Fee. Each application for initial licensure of an Abortion Facility shall be accompanied by a fee of five hundred dollars ($500). The fee shall be payable to the Arkansas Department of Health.

E. Renewal of License. A license, unless revoked, shall be renewable annually upon payment of a fee of five hundred dollars ($500) to the Arkansas Department of Health accompanied by an application for re-licensure. The application for annual license renewal along with the fee shall be postmarked no later than January 2 of the year for which the license is issued.

F. Issuance of License. A license shall be issued only for the premises, services, and person or persons reflected in the application. The license shall be posted in a conspicuous place in the Abortion Facility. The license shall be effective on a calendar year basis and shall expire on December 31 of each calendar year. The license shall not be transferrable and shall expire if a change of ownership occurs.

G. Change of Ownership. It shall be the responsibility of the Abortion Facility to notify the

Division of Health Facility Services in writing at least thirty (30) days prior to the effective date of a change of ownership. The following information shall be submitted for review and approval:

1. license application;

2. five hundred dollars ($500) change of ownership fee; and

3. legal documents, ownership agreements, and other information to support re-licensure requirements.

H. Management Contract. It shall be the responsibility of the Abortion Facility to notify the Division of Health Facility Services in writing at least thirty (30) days prior to entering into a management contract or agreement with an organization or firm. A copy of the contract or agreement shall be submitted for review to assure the arrangement does not affect the license status.

I. Closure. Once an Abortion Facility closes, it shall no longer be considered licensed. The license issued to the Abortion Facility shall be returned to the Division of Health Facility Services. To be eligible for re-licensure, the Abortion Facility shall meet requirements for new construction and all the current life safety and health regulations.

J. Inspection. Any authorized representative of the Arkansas Department of Health shall have the right to enter upon or into the premises of any Abortion Facility at any time in order to make whatever inspection it deems necessary in order to assure minimum standards and regulations are met.

SECTION 5. GOVERNING BODY.

An Abortion Facility shall have an organized Governing Body, consisting of at least one (1) member, which may be the Medical Director, with local representation which shall be legally responsible for maintaining patient care and establishing policies for the facility and shall be legally responsible for the conduct of the facility.

A. The Governing Body Bylaws. The Governing Body shall adopt written bylaws which shall ensure the following.

1 Maintenance of professional standards of practice;

2 Terms, responsibilities and methods of selecting members and officers;

3. Methods by which Quality Improvement is established; and

4. Compliance with federal, state and local laws.

B. Governing Body Minutes. The Governing Body minutes shall include at least the following information:

1. Review, approval and revision of the Governing Body bylaws, rules. regulations and protocols;

2 Review and approval of the Quality Improvement Plan for the facility at least annually, and review of Quality Improvement summaries at least quarterly.

C. Quality Improvement (QI) Program.

1. The Abortion Facility shall develop, implement, and maintain a QI program to include:

(a) Collection of data on the functional activities identified as priorities in QI and benchmark against past performance and national or local standards; and

(b) Development and implementation of improvement plans for identified issues, with monitoring, evaluation and documentation of effectiveness.

2 The scope of the QI Program shall include, but not be limited to, activities regarding the following:

(a) Assessment of processes and outcomes utilizing facility-specific clinical data;

(b) Evaluation of patient satisfaction;

(c) Evaluation of staff performance according to facility protocols; and

(d) Complaint resolution.

3. The facility shall evaluate the effectiveness of the QI Program annually and establish priorities for the QI Program.

SECTION 6. GENERAL ADMINISTRATION.

A. Each facility shall have an Administrator responsible for the management of the facility. The Medical Director may also function as facility administrator.

B. Policies and procedures shall be provided for the general administration of the facility and for each service. All policies and procedures shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date and signatures of the person(s) conducting the review.

C. Provisions shall be made for safe storage of patients' valuables.

D. Each facility shall develop and maintain a written disaster plan which includes provisions for complete evacuation of the facility. The plan shall provide for widespread disasters as well as for a disaster occurring within the local community or the facility. The disaster plan shall be rehearsed at least twice a year. One (1) drill shall simulate a disaster of internal nature and the other external. Written reports and evaluation of all drills shall be maintained.

E There shall be posted a list of names, telephone numbers, and addresses available for emergency use. The list shall include the key facility personnel and staff, the local police department, the fire department, ambulance service, Red Cross, and other available emergency units. The list shall be reviewed and updated at least every six (6) months.

F There shall be current reference material available onsite to meet the professional and technical needs of Abortion Facility personnel including current books, periodicals, and other pertinent materials.

G All employees shall be required to have annual in-services on safety, fire safety, back safety, infection control, universal precautions, disaster preparedness and confidential information.

H. Procedures shall be developed for the retention and accessibility of the patients' medical records if the Abortion Facility closes.

I Any Abortion Facility that closes shall meet the requirements for new construction in order to be eligible for re-licensure. Once a facility closes, it is no longer licensed. The license shall be immediately returned to Health Facility Services. To be eligible for licensure, all the referenced National Fire Codes (NFPA) and health regulations shall be met.

J Written consent for the performance of an induced abortion must be obtained and signed by the patient prior to the abortion and after counseling by a qualified professional. Written or verbal consent shall not release the facility or its personnel from upholding the rights of patients including, but not limited to, the right to privacy, dignity, security, confidentiality, and freedom from abuse or neglect.

K. Each facility shall have a Medical Director who shall be a physician currently licensed to practice medicine in Arkansas, and who shall be responsible for the direct coordination of all medical aspects of the facility program.

L. There shall be written policies and procedures developed and approved by the Medical Director and Administrator which define the care provided at the facility.

M Policies and procedures shall include, but not be limited to the following:

1. personnel policies;
2. provision of medical and clinical services;
3. provision of laboratory services;
4. examination of fetal tissue;
5. disposition of medical waste;
6. emergency services;
7. criteria for discharge;
8. health information systems (including electronic records);
9. provision of pharmacy services;
10. medication administration;
11. anesthesia/analgesia/sedation administration as applicable;
12. counseling services;
13. patient education;
14. infection control, including post- abortion surveillance;
15. fire, safety, and disaster preparedness;
16. housekeeping;
17. laundry;
18. preventive maintenance;
19. processing and/or storage of sterile supplies;
20. patient care;
21. probable post-fertilization age determination; and
22. proper disposition of dead fetuses and fetal remains.

N. Administrative Reports. The Administrator or his/her designee shall report: infectious or communicable diseases to the Arkansas Department of Health, as required by:

1. the Rules and Regulations Pertaining to Communicable Disease in Arkansas (Ark. Code Ann. §§ 20-7-109, 110.); and

2. the Rules Pertaining to the Control of Communicable Diseases-Tuberculosis.

O Each facility shall ensure that each dead fetus or fetal remains are disposed of in accordance with the provisions of Ark. Code Ann. § 20-17-102.

1. The requirements of this subsection shall not apply to abortions induced by the administration of medications when the evacuation of any human remains occurs at a later time and not in the presence of the inducing physician nor at the facility in which the physician administered the inducing medications.

SECTION 7. PATIENT CARE SERVICES.

An Abortion Facility shall have an adequate number of personnel qualified under this section available to provide direct patient care as needed.

A. Qualifications.

1. Only physicians who are currently licensed to practice medicine in Arkansas may perform abortions.

2 All facility personnel, medical and others, shall be licensed to perform the services they render when such services require licensure under the laws of the State of Arkansas. Documentation of current licensure shall be maintained in the personnel file for each employee.

3. Providers of patient counseling shall, at a minimum, possess current licensure as a nurse, Social Worker, or documented experience and training in a related field. Special training in counseling which is deemed acceptable by the Department shall be required.

4. All clinical staff of the facility shall be required to provide documentation of training and continued competence in cardiopulmonary resuscitation (CPR) or its equivalent.

B. Staffing Requirements.

1 There shall be a sufficient number of Registered Nurses in the facility at all times when patients are present.

2. Registered Nurses shall be on duty to supply or supervise all nursing care of patients.

C. Authority and responsibilities of all patient care staff shall be clearly defined in written policies, including periodic monitoring and assessment of patients.

D. Services shall be organized to ensure management functions are effectively conducted. These functions shall include, but are not limited to:

1. review of policies and procedures at least annually to reflect current standards of care;

2 establishment of a mechanism for review and evaluation of care and services provided at the facility;

3 orientation and maintenance of qualified staff for provision of patient care;

4 annual in-service education programs for professional staff; and

5 provision of current nursing literature and reference materials.

E. Patients shall have access to twenty-four (24) hour telephone consultation with either a

Registered Nurse or physician associated with the facility.

F. A Registered Nurse shall plan, supervise, and evaluate the nursing care of each patient from admission to the facility through discharge.

G. Counseling services shall be provided for each patient, as follows:

1. prior to the abortion, the patient shall be counseled regarding the abortion procedure, alternatives to abortion, informed consent, medical risks associated with the procedure, potential post-abortion complications, community resources and family planning;

2. documentation of counseling shall be included in the patient's medical record;

3. if counseling is performed in groups, the patient shall be offered an opportunity to meet privately with a qualified counselor;

4. each patient shall be assessed by a Registered Nurse for counseling needs post-abortion;

5. written instructions for post-abortion care shall be given to the patient at discharge, to include at least the following:

   (a) signs and symptoms of possible complications;

   (b) activities allowed and to be avoided;

   (c) hygienic and other post-discharge procedures to be followed;

   (d) abortion Facility emergency telephone numbers available on a twenty-four (24) hour basis; and

   (e) follow up appointment, if indicated.

6. The patient shall be counseled regarding Rh typing and shall be given Rh immune globulin, if indicated.

SECTION 8. PROGRAM REQUIREMENTS.

A Admission Evaluation. Every woman seeking to have an abortion shall be registered by the facility and evaluated by means of a history, physical examination, counseling, and laboratory tests.

1. Verification of Pregnancy. Pregnancy testing shall be available to the patient and may precede actual registration by the facility. No abortion shall be performed unless the examining physician verifies the patient is pregnant. Pregnancy test results shall be filed in the patient's medical record.

2. History and Physical Examination. Prior to the abortion, a medical history shall be obtained and recorded. The patient shall be given an appropriate physical examination, as determined by the physician, which may include testing for sexually transmitted diseases. The facility shall report positive test results for sexually transmitted diseases to the Department of Health, as required. Pelvic examinations shall be performed only by qualified personnel, as defined by their Practice Acts.

3. Pre- abortion Tests. The following are required prior to an abortion: hematocrit or hemoglobin, Rh typing, and onsite proof of pregnancy, such as pregnancy test, copy of a pregnancy test or ultrasound. Other testing may be performed according to facility policy.

4. Counseling. Patient counseling services shall be offered prior to initiation of any abortion and if indicated following the abortion. In addition to verbal counseling, patients shall be given and allowed to keep printed materials.

B. Transfer. The Abortion Facility shall have written procedures for emergency transfer of a patient to an acute care facility.

C. Anesthetic agents.

1. Anesthesia, analgesia and anoxiolysis shall be administered only by a qualified professional acting within the scope of his or her Arkansas license.

2. Anesthesia administration in Abortion Facilities shall be limited to local anesthesia, minimal sedation, and moderate sedation.

D Discharge criteria, developed by the clinical staff and approved by the Governing Body, may be utilized to evaluate patients' medical stability for discharge. Patients may be discharged only on the order of a physician. Patients receiving sedation shall be discharged in the company of a responsible adult.

E. Complications.

1. General Abortion Facilities shall have emergency drugs, oxygen and intravenous fluids available to stabilize the patient's condition, when necessary. An ambu bag, suction equipment and endotracheal equipment shall be located in the clinical area for immediate access.

2. Medical-Only Abortion Facilities shall have oxygen, medication, oral airways and supplies available.

3. All clinical staff shall have documented current competency in cardiopulmonary resuscitation (CPR).

F. Report of Induced Termination. In accordance with Act 120 of 1981, each induced termination of pregnancy which occurs in Arkansas shall be reported to the Division of Health Statistics on a monthly basis by the person in charge of the Abortion Facility.

G. Denial, Suspension or Revocation. The Department may deny, suspend or revoke the license of any Abortion Facility on the following grounds: violation of any of the provisions of the Act or Rules and Regulations lawfully promulgated hereunder; and/or conduct or practices detrimental to the health or safety of patients and employees of any such facilities. This provision shall not be construed to have any reference to healing practices authorized by law.

SECTION 9. HEALTH INFORMATION SERVICES.

The Abortion Facility shall maintain a system for the completion and storage of the medical record. The record shall provide a format for continuity and documentation of legible, uniform, complete, and accurate patient information readily accessible and maintained in a system that ensures confidentiality.

A. General Requirements.

1. The Abortion Facility shall adopt a record form for use that contains information required for transfer to an acute care facility.

2. Record reviews with criteria for identification of problems and follow up shall be reported to the Medical Director at least quarterly.

3. Responsibility for the processing of records is assigned to an individual employed by the Abortion Facility.

4. All medical records shall be retained in either the original, microfilm, or other acceptable methods for ten (10) years after the last discharge.

5. The original or a copy of the original (when the original is not available) of all reports shall be filed in the medical record.

6. The record shall be permanent and shall be either typewritten or legibly written in blue or black ink.

7. All typewritten reports shall include the date of dictation and the date of transcription.

8. All dictated records shall be transcribed within forty-eight (48) hours.

9. Errors shall be corrected by drawing a single line through the incorrect data, labeling it as "error", initialing, and dating the entry.

10. Policies and procedures for Health Information Services shall be developed. The manual shall have evidence of ongoing review and/or revision. The first page of the manual(s) shall have the annual review date and signatures of the person(s) conducting the review.

11 Medical records shall be protected to ensure confidentiality, prevent loss, and ensure reasonable availability.

12. All medical records, whether stored within the facility or away from the facility shall be protected from destruction by fire, water, vermin, dust, etc.

13. Medical records shall be considered confidential. All medical records (including those filed outside the facility) shall be secured at all times. Records shall be available to authorized personnel from the Arkansas Department of Health.

14. Written consent of the patient or legal guardian shall be presented as authority

for release of medical information. There shall be policies and procedures developed concerning all phases of release of information.

15. Original medical records shall not be removed from the facility except upon receipt of a subpoena duces tecum by a court having authority for issuing such an order.

16. Medical records shall be complete and contain all required signed documentation no later than thirty (30) days following the patient's discharge.

17. After the required retention period, medical records may be destroyed by burning or shredding. Medical records shall not be disposed of in landfills or other refuse collection sites.

18. Each entry into the medical record shall be authenticated by the individual who is the source of the information. Entries shall include all observations, notes, and any other information included in the record.

19. Signatures shall be, at least, the first initial, last name, and title. Computerized signatures may be either by code, number, initials, or the method developed by the facility.

20 There shall be policies and procedures for use of electronic medical records. The policies and procedures shall provide for the use, exchange, security, and privacy of electronic health information. The policies and procedures shall provide for standardized and authorized availability of electronic health information for patient care and administrative purposes. The policies and procedures will be in compliance with current guidelines and standards as established in federal and state statutes

B. Record Content. Each record shall include but not be limited to documentation of:

1. demographic and patient information;

2. informed consent;

3 complete family, medical, social, reproductive, nutrition, and behavioral history;

4 initial physical examination, evaluation of risk status, and laboratory test results;

5 appropriate referral of patients, as indicated;

6 documentation of each periodic examination;

7 patient counseling regarding the abortion, alternatives to abortion, informed consent, medical risks associated with the abortion, potential post-abortion complications, available community resources, and family planning;

8 patient education regarding post-abortion signs and symptoms of possible complications, activities allowed and to be avoided, hygienic and other post-

discharge procedures to be followed, telephone numbers to access emergency care, and follow-up appointments; and

9. abortion and post-abortion records.

SECTION 10. INFECTION CONTROL FOR ABORTION FACILITIES.

A. General.

1. The facility shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in patients, and health care workers.

2. The facility shall follow standard Center for Disease Control and Prevention (CDC) precautions.

3. There shall be policies and procedures establishing and defining the Infection Control Program, including:

(a) definitions of nosocomial infections which conform to the current CDC definitions;

(b) methods for obtaining reports of infections in patients and health care workers in a manner and time sufficient to limit the spread of infections;

(c) measures for assessing and identifying patients and health care workers at risk for nosocomial infections and communicable diseases;

(d) measures for prevention of infections;

(e) provisions for education of patients and family concerning infections and communicable diseases, including hand hygiene and isolation precautions;

(f) plans for monitoring and evaluating all infection control policies and procedures;

(g) techniques for:

(1) hand hygiene including procedures for soap and water as well as alcohol based hand rub if used;

(2) scrub technique (applies only to General Abortion Facilities);

(3) asepsis;

(4) sterilization;

(5) disinfection;

(6) housekeeping;

(7) linen care;

(8) liquid and solid waste disposal of both infectious and regular waste. Disposal of infectious waste shall conform to the latest

edition of the Rules and Regulations Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities;

(9) policy for disposal of products of conception;

(10) sharps and needle disposal;

(11) separation of clean from dirty processes; and

(12) other means of limiting the spread of contagion;

(h) a requirement that disinfectants, antiseptics, and germicides be used in accordance with the manufacturer's directions;

(i) employee health.

4. There shall be an orientation program for all new health care workers concerning the importance of infection control and each health care worker's responsibility in the facility's Infection Control Program.

5. There shall be a plan for each employee to receive annual in services and educational programs, as indicated, based upon assessment of the infection control process.

B. Employee Health.

1 The facility shall develop policies and procedures for screening health care workers for communicable diseases and monitoring health care workers exposed to patients with any communicable diseases.

2. There shall be policies regarding health care workers with infectious diseases or carrier states. The policies shall clearly state when health care workers shall not render direct patient care.

NOTE: Health care workers employed by the facility who are afflicted with any disease in a communicable stage, or while afflicted with boils, jaundice, infected wounds, diarrhea, or acute respiratory infections, shall not work in any area in any capacity in which there is a likelihood of such person contaminating food, food contact surfaces, supplies, or any surface with pathogenic organisms or transmitting disease to patients, facility personnel or other individuals within the facility.

3. There shall be a plan for ensuring that each health care worker has an annual tuberculosis skin test or is evaluated in accordance with current Arkansas Department of Health Rules and Regulations Pertaining to the Control of Communicable Disease - Tuberculosis.

4. There shall be a plan for ensuring that all health care workers who are frequently exposed to blood and other potentially infectious body fluids are offered immunizations for hepatitis B.

C. Reporting. Infectious and communicable diseases shall be reported to the Arkansas Department of Health in accordance with the most current versions of:

1 Rules and Regulations Pertaining to Comunicable Disease in Arkansas; and

2. the Rules Pertaining to the Control of Communicable Diseases-Tuberculosis.

SECTION 11. PHARMACEUTICAL SERVICES.

A. Organization.

1. Abortion Facilities shall have provisions for pharmaceutical services regarding the procurement, storage, distribution and control of all medications. The Abortion Facility shall be in compliance with all state and federal regulations.

2. Pharmaceutical services shall be under the direction of a licensed pharmacist if required by State law. In case the Abortion Facility does not require a licensed pharmacist, the Medical Director shall assume the responsibility of directing Pharmaceutical Services. A licensed pharmacist means any person licensed to practice pharmacy by the Arkansas State Board of Pharmacy who provides pharmaceutical services as defined in the Pharmacy Practice Act. The pharmacist or Medical Director shall make provisions that shall include, but not be limited to:

   (a) development and implementation of pharmacy policies and procedures;

   (b) annual review and revisions of pharmacy policies and procedures, with documentation of dates of review;

   (c) maintenance of medications in the Abortion Facility to meet the needs of the population served;

   (d) maintenance of medications in the Abortion Facility to ensure accountability; and

   (e) proper storage of medications.

B. Staffing. Pharmaceutical services shall be provided by a licensed pharmacist or Medical Director as required by State law. If the service is provided by a consulting pharmacist, it may be done so on a consulting basis. Onsite consultation by the pharmacist shall be required at least monthly. Documentation of each consultation visit shall be recorded and maintained at the Abortion Facility. Documentation of each visit shall include compliance with, but not be limited to:

1. proper storage of drugs;

2. disposal of medications no longer needed, discontinued, or outdated;

3. proof of receipt and administration of controlled substances and proper storage of such medications;

4. verification that medications in stock conform to the specified quantities on posted lists;

5. proper labeling; and

6. maintenance of emergency carts or kits.

If the service is under the direction of the Medical Director, he/she may designate the above required monthly documentation to a licensed nurse.

C. Policies and Procedures. There shall be pharmacy policies and procedures to include, but not be limited to:

1. detailed job description of the licensed pharmacist and/or Medical Director;
2. procurement of medications;
3. distribution and storage of medications;
4. a listing of stock medications with minimum and maximum quantities to be maintained in the Abortion Facility;
5. a listing of medications with exact quantities to be maintained in emergency kits;
6. destruction of deteriorated, non-sterile, unlabeled, or damaged medications;
7. listing controlled substances to be destroyed on the proper forms and either sending a copy of the form with the medications to the Arkansas Department of Health by registered mail or delivering the form and medications in person;
8. maintenance of all drug records for a minimum of two (2) years;
9. maintenance of medications brought to the Abortion Facility;
10. drug recalls;
11. reporting of adverse drug reactions and medication errors to the attending physician and the Governing Body;
12. accountability of controlled substances;
13. reporting of suspected drug loss, misuse, or diversion, according to state law;
14. use of Automatic Medication Dispensing Devices, if applicable.

D. Drug storage and security. Medications maintained at the Abortion Facility shall be properly stored and safeguarded to ensure:

1. locked storage of all medications;
2. proper lighting and ventilation, as required by the manufacturer;
3. proper temperature controls with daily temperature documentation of medication refrigerators to ensure storage between thirty-six (36) and forty-six (46) degrees Fahrenheit, or two (2) to eight (8) degrees Centigrade;

4 separate storage of biologicals and medications from food;

5. accessibility to licensed personnel only; and

6. proper use of any Automatic Medication Dispensing Devices.

E. Controlled Substances.

1. Controlled drugs shall be double locked.

2. A record of the procurement and disposition of each controlled substance shall be maintained in the Abortion Facility and be readily retrievable. Each entry on the disposition record shall reflect the actual dosage administered to the patient, the patient's name, date, time, and signature of the licensed person administering the medication. The signature shall consist of a first initial, last name, and title. (Licensed personnel who may legally administer controlled substances shall include only those personnel authorized by their current Practice Act and licensed by the Arkansas State Medical Board or Arkansas State Board of Nursing.) Any error of entry on the disposition record shall follow a policy for correction of errors and accurate accountability. If the licensed person who procures medication from the double locked security is not the licensed person who administers the medication, then both persons shall sign the disposition record;

3. When breakage or wastage of a controlled substance occurs, the amount given and amount wasted shall be recorded by the licensed person who wasted the medication and verified by the signature of a licensed person who witnessed the wastage. Documentation shall include how the medication was wasted In addition to the above referenced licensed personnel, licensed pharmacists shall be allowed to witness wastage of controlled substances. When a licensed person is not available to witness wastage, the partial dose shall be sent to the Arkansas Department of Health, Division of Pharmacy Services and Drug Control for destruction;

4. There shall be an audit each shift change of all controlled substances stocked in the Abortion Facility which shall be recorded by an oncoming nurse and witnessed by an off-going nurse. If only one (1) shift exists, an audit shall be conducted at the opening and closing of the abortion facility daily. If discrepancies are noted, the Director of Nursing, Pharmacy Consultant and/or Medical Director shall be notified. As with the witnessing of wastage, licensed pharmacists shall be allowed to witness controlled substance audits;

5. Records generated by Automatic Dispensing Devices shall comply with these requirements.

F. Medications.

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1. All verbal or telephone orders for medications shall be received by a licensed nurse or Registered Pharmacist and reduced to writing into the patient's medical record. Verbal or telephone orders shall be countersigned by the practitioner within twenty-four (24) hours. Signed facsimile orders are acceptable, provided the facsimile paper is of a permanent nature.

2. The Abortion Facility may procure medications for its patients through community pharmacists, or medications may be procured through the facility's physician.

SECTION 12. PHYSICAL FACILITIES, ABORTION FACILITIES.

A. Definitions.

1. **Accessible** - barrier free; approachable by all peoples including those with physical disabilities.

2. **Addition** - an extension or increase in floor area and/or height of an existing building, or structure.

3. **Alter or Alteration** - any change(s) and modification in construction, occupancy, installation, or assembly of any new structural components, and any change(s) to the existing structural component, in a system, building, and structure.

4. **And/Or** (in a choice of two (2) code provisions) - signifies use of both provisions shall satisfy the code requirements and use of either provision is acceptable, also. The most restrictive provision shall govern. Where there is a conflict between a general requirement and a specific requirement, the specific or restrictive requirement shall be applicable.

5. **Architect** - a duly registered professional licensed by the Arkansas State Board of Architects to use the title "architect."

6 **Corridor** - a passage way into which compartments or rooms open and which is enclosed by partitions and/or walls and a ceiling, or a floor/roof deck above.

7. **Engineer** - duly registered professional licensed by the Arkansas Board of Registration for Professional Engineers and Land Surveyors to use the title "engineer."

8. **New construction** - the assembly of a new free standing structure.

9. **Renovation** - construction performed within an existing facility.

10. **Room** - a separate, enclosed space, with doorway(s), for the one (1) named function.

11. **Toilet** - a room designed exclusively for a water closet and lavatory.

B. Plan Review. Plans for all new construction and/or alterations shall include site requirements, preliminary drawings, submission of plan review fee, final construction documents, letter of approval for construction documents, site observation and final site observation.

1. No new mechanical, electrical, plumbing, fire protection, or medical gas system shall be installed, nor any such existing system materially altered or extended, until complete drawings and specifications for installation, alteration, or extensions have been submitted to the Division for review and approval.

2. Site Requirements.

(a) The site location shall be easily accessible to the community and to service vehicles such as fire protection apparatus.

(b) The Abortion Facility shall have security measures for patients, personnel, and the public consistent with the conditions and risks inherent in the location of the facility.

(c) Site utilities shall be reliable (water, natural gas, sewer, electricity and communication). The water supply shall have the capacity to provide normal usage plus fire fighting requirements. The electricity shall be of stable voltage and frequency.

(d) The site shall afford good drainage and shall not be subject to flooding.

(e) Soil bearing capacity shall be sufficient to support the building and paved areas.

(f) Paved access roads and walks shall be provided within the boundary of the property to public service and emergency entrances.

(g) Paved parking spaces shall be provided to satisfy the needs of patients, employees, staff, and visitors. In the absence of a formal parking study, each facility shall provide not less than one (1) space for each day shift staff member and employee plus one (1) space for each patient bed/recliner. Parking spaces shall be provided for emergency and delivery vehicles.

3. Preliminary Drawings. Schematic drawings for the Abortion Facility shall be submitted to the Division. These drawings shall illustrate a basic understanding of the architectural, mechanical, electrical and plumbing systems. Schematic drawings shall include schematic plans, building sections, exterior elevations (all sides), preliminary finish schedule, and general notes. Code criteria shall be submitted that is specific to the proposed facility and exhibits knowledge of the building and fire code requirements including but not limited to construction type, fire protection ratings, means of egress and smoke compartmentalization. Drawings shall be at a scale to clearly represent the intent. A graphic and/or written scale and directional arrow shall be on each drawing.

4 Submission of Plan Review Fee. A plan review fee in the amount of one (1) percent of the total cost of construction or five hundred dollars ($500.00), whichever is less, shall be paid for the review of drawings and specifications. The plan review fee check is to be made payable to the Division of Accounting, Arkansas Department of Health. A detailed estimate must accompany the plans unless the maximum fee of five-hundred dollars ($500.00) is paid. The Division will coordinate review of plans for all Arkansas Department of Health offices.

5. Final Construction Documents.

(a) Plans and specifications shall be prepared by an architect and/or engineer licensed by the State of Arkansas. The architect and engineer shall prepare and submit construction documents with the respective seals for each professional discipline. Architectural construction documents shall be prepared by an architect, and engineering (mechanical, electrical, civil and structural) construction documents shall be prepared by an (mechanical, electrical, civil and structural) engineer. Periodic observations of construction shall be provided and documented by each design professional to assure that the plans and specifications are followed by the contractor, and that "as build" prints are kept current. The interval for periodic observation shall be determined and approved by the Division prior to beginning construction.

(b) Working drawings and specifications shall be prepared in a manner that clearly defines the scope of the work and is consistent with the professional standard of practice for architects and engineers. Working drawings and specifications shall be complete for contract purposes.

(c) Final construction documents shall be reviewed and approved by the Division prior to the beginning of construction. The Division shall have a minimum of six (6) weeks to review final construction documents after which time an approval letter shall be issued. Plan review with other Health Department Divisions shall be coordinated by the Division.

6 Site Observation During Construction. The Abortion Facility shall be observed during construction and before occupancy.

(a) The Division shall be notified when construction begins and a construction schedule shall be submitted to determine inspection dates.

(b) Representatives from the Division shall have access to the construction premises and the construction project for purposes of making whatever inspections deemed necessary throughout the course of construction.

(c) Any deviation from the approved construction documents shall not be permitted until a written construction addenda or change order is approved by the Division.

7. Final Site Observation.

(a) Upon completion of construction and prior to occupancy approval by the Division, the owner shall be furnished one (1) complete set of contract documents, plans and specifications showing all construction, fixed equipment, and mechanical and electrical systems as installed or built. In addition, the owner shall be furnished a complete set of installation, operation, and maintenance manuals and parts lists for the installed equipment.

(b) No Abortion Facility shall occupy any new construction, addition, renovation and/or alteration until approval has been granted from all city, county, and other state regulatory agencies in addition to the Division.

C. General Considerations.

1. The requirements set forth herein have been established as minimum requirements for new construction, addition(s), renovation(s) and alteration(s) in Abortion Facilities requiring licensure under these regulations.

2. Abortion Facilities undertaking new construction, an addition, renovation, and/or alteration shall minimize disruption of existing functions. Access, exits and fire protection shall be maintained for occupancy safety.

3. The building and equipment shall be maintained in a state of good repair at all times.

4. The premises shall be kept clean, neat, free of litter and rubbish.

D. Codes and Standards.

1. Nothing stated herein shall relieve the owner from compliance with building, fire, subdivision and zoning codes, ordinances, and regulations of city, county and other state agencies.

2. Compliance with referenced codes and standards shall be that of the latest edition(s).

3. Accessibility requirements shall be those set forth by the Arkansas State Building Services, Minimum Standards and Criteria - Accessibility for the Physically Disabled Standards.

4. Electrical Systems. Electrical devices shall be installed in accordance with NFPA 70, National Electrical Code.

5. Mechanical Systems.

(a) HVAC systems shall be installed in accordance with the Arkansas State Mechanical Code.

(b) Air ventilation and filtering requirements shall be in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality and ASHRAE 52, Filter Efficiencies.

6. Plumbing and Gas Systems

(a) Plumbing systems shall be installed in accordance with the Arkansas State Plumbing Code.

(b) Gas systems shall be installed in accordance with the Arkansas State Gas Code.

7. New Abortion Facilities shall meet the criteria of NFPA 101, Life Safety Code, Chapter 26, New Business Occupancies. Existing buildings proposed for use as Abortion Facilities shall meet the criteria of NFPA 101, Life Safety Code, Chapter 27, Existing Business Occupancies. Both new Abortion Facilities and existing buildings proposed for use as Abortion Facilities shall meet the following additional requirements:

(a) Emergency lighting shall be connected to rechargeable back-up (ninety (90) minute minimum duration) batteries as a means of emergency illumination for procedure rooms, corridors, stairways, exit signs and at the exterior of each exit.

(b) A protected premises fire alarm system as defined in NFPA 72, National Fire Alarm Code, Chapter 3 shall be required.

(c) Fire extinguisher(s) shall be easily accessible and shall be provided, located, and inspected as defined in NFPA 10, Standard for Portable Fire Extinguishers.

(d) At least two (2) separate exits that are remote from each other shall be provided on every story of Abortion Facility use.

(e) The minimum clear door opening for patient use shall be two (2) feet eight (8) inches.

(f) Gas fired equipment rooms shall be separated with one (1) hour fire resistance partitions.

(g) No operable fireplace shall be permitted. Inoperable fireplace(s) shall be sealed at the upper and lower portions of the flue.

(h) Cabinets or casework in patient use areas shall be furred to the ceiling above or provided with sloping tops to facilitate cleaning.

(i) A panic bar releasing device shall be provided for all required exit doors subject to patient traffic.

(j) Medical gas. air and vacuum systems, if provided, shall meet installation, testing, maintenance and certification criteria of NFPA 99, Standard for Health Care Facilities.

E Design Considerations

1. Each Abortion Facility design shall ensure patient acoustic and visual privacy during interview, examination, treatment and recovery.

2 The premises shall be kept free from insect and vermin infestation.

3. The building shall be well ventilated at all times with a comfortable temperature maintained.

4. Space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, containment or removal, or by a combination of these techniques.

5. Waiting/Reception area(s) shall be provided with sufficient seating for the maximum number of people that may be waiting at any one (1) time. A reception and information counter or desk shall be provided.

6 A barrier free public toilet rooms shall be provided. This room may be conveniently located outside the Abortion Facility as part of shared tenant spaces in the same building.

7. Public telephone(s) shall be provided.

8. A housekeeping room with mop sink shall be provided

9. Storage space shall be provided for both administrative and clinical needs.

10 A business office room shall be provided

11 A medical records storage room shall be provided. This room shall protect records against undue destruction from dust, vermin, water, smoke and fire. It shall be constructed as a one (1) hour fire resistance rated enclosure and protected by a smoke detection system connected to the fire alarm. Storage for records shall be accessible and at least six (6) inches above the floor.

12. A consultation room shall be provided.

13 An examination room shall be provided. The examination room shall have a minimum floor area of eighty (80) square feet excluding fixed millwork, vestibule, toilet and closets. The room shall contain an examination table and chair, charting counter or desk, instrument table and shelves, hand-washing sink and equipment storage as needed. Room arrangement shall permit at least three (3) feet clearance at each side and at the foot of the examination table. Entry door swing and view angles shall maximize patient privacy. This room may be combined with the procedure room.

F. Interior Finishes.

1. Interior finishes shall meet the flame spread and smoke development requirements of NFPA 101, Life Safety code.

2 Finished floors, ceilings and walls shall be provided for all rooms and spaces except mechanical and electrical rooms.

3 Procedure rooms and soiled work rooms shall have a monolithic finish floor and base, stain resistant for its intended use and integral with each other (i.e., sheet vinyl floor with continuous sheet vinyl base). Seams in the monolithic floor and

base shall be chemically welded.

4. Toilet rooms, clean work rooms, housekeeping rooms and examination rooms (when combined with the procedure room) shall not have a carpeted floor finish.

5. Procedure rooms, soiled work rooms and clean work rooms shall have smooth, washable, moisture resistant, ceilings of gypsum board, plaster or mylar faced lay-in ceiling tiles.

6. Wall finishes for all rooms shall be smooth, moisture resistant and washable.

G. General Abortion Facilities: additional requirements. In addition to the preceding requirements, General Abortion Facilities shall also meet the requirements below.

1. A procedure room shall be provided. The procedure room shall have a minimum floor area of one-hundred-twenty (120) square feet excluding fixed millwork, vestibule, toilet and closets. The minimum room dimension shall be ten (10) feet. The room shall contain a handwash sink with hands-free controls, soap dispenser and single service towel dispenser.

2. One (1) or more recovery rooms shall be provided. A recovery room shall have a minimum of sixty (60) square feet per patient excluding fixed millwork, vestibule, toilet and closets. The room shall contain a bed or a washable, reclining chair. Multi-patient recovery rooms shall be provided with cubicle curtains for patient privacy.

3. A clean work room shall be provided sufficient in size to process clean and sterilize supply materials and equipment. This room shall contain a handwash sink, work counter and autoclave adequate in size to sterilize the equipment in use.

4. A soiled work room shall be provided. This room shall contain a handwash sink and work counter.

5. At least one (1) barrier free, patient toilet room shall be provided for each recovery room.

SECTION 13. CERTIFICATION.

CERTIFICATION

It is found and determined by the Board of Health that this rule is necessary to clarify mandates placed on abortion facilities in Arkansas as a result of the passage of Act 603 of 2017. Act 603 will become effective on July 31, 2017. The Act is unclear if abortion facilities would be responsible for the disposition of dead fetuses and fetal tissue when the evacuation occurs outside the presence of the inducing physician or away from the facility in which the physician administered the inducing medications. Therefore, an emergency is hereby declared to exist and this Rule, being necessary for the immediate preservation of the public peace, health and safety, shall be in full force and effect from and after July 31, 2017.

This will certify that the foregoing revisions to the Rules and Regulations for Abortion Facilities in Arkansas 2017 were adopted by the State Board of Health of Arkansas at a special session of said Board held in Little Rock, Arkansas, on the 19th day of July, 2017.

Nate Smith, M.D., MPH
Secretary of Arkansas State Board of Health
Director, Arkansas Department of Health

Date

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Health

DIVISION Center for Health Protection/Health Facilities Section

DIVISION DIRECTOR Renee Mallory

CONTACT PERSON Robert Brech

ADDRESS 4815 West Markham, St., Slot 31, Little Rock, AR

PHONE NO. 501-661-2297 **FAX NO.** 501-661-2357 **E-MAIL** robert.brech@arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Robert Brech

PRESENTER E-MAIL robert.brech@arkansas.gov

INSTRUCTIONS

A. **Please make copies of this form for future use.**
B. **Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
C. **If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
D. **Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Abortion Facilities in Arkansas

2. What is the subject of the proposed rule? Disposition of fetal tissue

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☒ No ☐
   If yes, what is the effective date of the emergency rule? 11-14-2017

   When does the emergency rule expire? 3-14-2018

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☒ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Act 603 of 2017

7. What is the purpose of this proposed rule? Why is it necessary? To clarify that abortion facilities are not responsible for fetal remains expelled away from their facilities.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
http://www.healthy.arkansas.gov/aboutADH/Pages/RulesRegulations.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: 11/13/2017
Time: 10:00
Place: Suite 801, 5800 West Tenth Street, Little Rock, Arkansas

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
11/13/2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
3/15/17

12. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain. The Department is not aware of any significant controversy at this time regarding this rule.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Health
DIVISION Center for Health Protection/Health Facilities Section
PERSON COMPLETING THIS STATEMENT Robert Brech
TELEPHONE NO. 501-661-2297 **FAX NO.** 501-661-2357 **EMAIL:** robert.brech@arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Abortion Facilities in Arkansas

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost:
   N/A

   (b) The reason for adoption of the more costly rule:
   N/A

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain: and;
   N/A

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.
   N/A

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
Genera Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs:

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Bettina E. Brownstein Law Firm
904 W. Second St, Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: [redacted]

October ~~12~~ 11, 2018

Ann Purvis, Esq.
Deputy Director for Administration
Arkansas Dept. of Health
4815 W. Markham St.
Little Rock, AR 72205

Re: In the Matter of Arkansas Dept. of Health v. Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains

Dear Ann:

Enclosed please the following:

(1) Reply to Response of ADH to Appeal:

(2) Supplementary Affidavit of Nathan Johnson:

(3) Letter affidavit requesting disqualification of certain Board members.

Cordially,

Bettina E. Brownstein

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH	**PETITIONER**
V.	
LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS	**RESPONDENT**

RESPONDENTS' REPLY TO RESPONSE OF ADH TO APPEAL OF DEFICIENCY FINDINGS AND MOTION TO DISMISS DEFICIENCY CITATIONS

Respondents provide this reply in further support of their appeals of the March 13 and 23, 2018, Arkansas Department of Health ("ADH") Statements of Deficiencies. ADH's response does not address Respondents' numerous constitutional arguments against ADH's enforcement actions, addresses only the last few pages of Respondents' 27-page opening brief, does not contest any of Respondents' factual evidence, and concedes there are no facts in dispute. *See* Response, p.1. Respondents, therefore, reply only to ADH's limited arguments before the Arkansas Board of Health ("Board"), fully reserving all of their federal and Arkansas constitutional claims against the asserted deficiencies and the Payment Ban. As Petitioner recognizes, these constitutional claims were necessarily asserted by Respondents in order to preserve them for appeal to the Courts, *see* Response p. 2, and they are so preserved.

ADH is not authorized to issue the Statements of Deficiencies in the absence of an applicable rule.

ADH has exceeded its authority in issuing deficiency citations in the absence of a rule or regulation. In response to this contention, ADH argues, without any citation to authority, (1) that

a rule is unnecessary because the language of 1703(d) is "plain and unequivocal." *see* Response. Issue 1(c), and (2) that it has the authority to issue the deficiency citations under A.C.A. §20-9-302. *See* Response. Issue 1(a).

As Respondents established in their opening submission. ADH recognized in 2016 that it lacked the authority to cite LRFPS for charging for services before the expiration of 48 hours because ADH had not promulgated any rule or regulation regarding this conduct. *See* Appeal. Exh. B (Brech Aug. 25 letter) to Exh. 1. ADH is still without any rule or regulation attempting to implement 1703(d) ("the Payment Ban"). and its short Response fails to explain why the absence of a rule no longer impacts its authority to issue a deficiency. Its assertion that a rule is simply "unnecessary" is contradicted by ADH's own position in 2016.

ADH also errs in arguing that a rule is unnecessary because the Payment Ban purportedly involves a "remedial" statute that "require[s] a liberal construction." *See* Response 1(d). To the contrary. this case concerns abortion facility licensing penalties. and the Arkansas courts are clear that statutes imposing such penalties must be strictly construed in favor of the licensee. not liberally construed in favor of the state. *See Wilcox v. Safley*. 298 Ark. 159. 161. 766 S.W.2d 12. 13 (1989) ("Code provisions imposing penalties for noncompliance with licensing requirements ... must be strictly construed.")

More fundamentally. the Board of Health is a statutory creation. It cannot exceed its explicit statutory authority. which is to "make all necessary and reasonable rules and regulations of a general nature for . . . the protection of the public health and safety." *See* A.C.A. §20-7-109. Petitioner is "the state agency responsible for implementing the Board's regulations." *See* [redacted]. A review of all laws pertaining to the creation and administration of both the Board and the department refer to its powers solely in

terms of rules and regulations. *See generally*, §25-9-101 *et. seq.* As stated in the ADH Guide to Administrative Procedure, the Arkansas State Board of Health (the "Board") and ADH are authorized by law to create and enforce **rules and regulations** to protect the health of Arkansans." Nowhere is it conferred upon ADH or the Board the power to enforce a state statute absent an appropriate rule or regulation. *See*

. Moreover, in §20-16-1508, the Legislature specifically instructed the Board to "adopt rules to implement the subchapter," of which the Payment Ban is a part. Since 2015, when the Payment Ban was enacted, Petitioner has ignored this legislative mandate. Since there is no regulation implementing the Payment Ban, the deficiency citations issued to Respondents are improper and should be dismissed.

In addition, ADH's issues 1(c) and 1(f) in its Response are irrelevant and offer no support for these deficiencies. The "informed consent signatures" referenced in ADH's point 1(c) are those specified in §20-16-1703(b)(6)(a), which requires a patient to sign a check-list after receiving the information required for informed consent in Arkansas. That check-list signature requirement does not incorporate or otherwise reference the Payment Ban. Moreover, the deficiencies cited in this case were not for any missing signed forms or missing informed consent materials. *Cf.* §20-16-1703(b) & (e). Finally, the licensing statute itself requires the department to "Adopt appropriate rules . . . [for] procedures" and "informed consent signatures" to "meet statutory requirements." §20-9-302(b)(1). Despite this legislative mandate, there is no rule, appropriate or otherwise, pertaining to the Payment Ban.

ADH acted in an arbitrary and capricious manner in issuing the March 2018 deficiency citations.

In their appeals, Respondents argue that ADH's issuance of the March 2018 deficiency citations was arbitrary and capricious because a previous inspection by ADH concerning the same conduct, *see* Appeal, Exh A to Exh 1, resulted in a finding that LRFPS was in compliance with all ADH rules and regulations and state laws. *See* Appeal, p. 5. Petitioner has responded to this argument by addressing a different prior deficiency finding, which is Exh. B to Exh. 1 to the Appeal, and ignoring the finding of no deficiency shown in Exh. A to Exh. 1. *See* Response, p. 5. While the deficiency citation that is the subject of this appeal is based on the 2017 amendment to the Payment Ban's provisions, this amendment did not change the terms of the ban; it merely expanded the categories of actors who might bill for physicians' services and thus be subject to that same ban. *See* Appeal, Exh.4 and Act 383 of 2107, attached to this Reply as Exh. 1

Two separate complaints concerning the Payment Ban resulted in ADH inspections of LRFPS in 2016. The first inspection, prior to May 16, 2016, resulted in no deficiency finding. *See* Appeal, Exh. A to Exh. 1; the second was dismissed by ADH because it lacked authority to issue it ---even though the physician's practice of charging for services provided at the patient's first visit at the time these services were provided was the same at both inspections. *See* Appeal, Exh. 1. If the physician's practice of charging patients before the expiration of the 48-hour reflection period violated 1709(d) in 2018, ADH should have issued a deficiency on May 16, 2016. It did not. The amendment's expansion of the Payment Ban provision to include other actors does not change the substance of the law. The only thing that changed was ADH's interpretation of the law.

In addition, even after Act 383 went into effect in August 2017, an ADH inspection in December of that year did not result in a deficiency citation for violation of the Payment Ban,

even though at that time, patients were being charged prior to the lapse of the 48-hour period. See Supplementary Affidavit of Lori Williams, attached as Exh. 2 to this Reply. So as late as December 2017, Petitioner did not consider charging at the patient's first visit to be a deficiency. Again, the only thing that changed between December 2017 and March 13, 2018, was Petitioner's interpretation of the law.

ADH's current interpretation and enforcement of 1703(d) results in nonpayment, not delay of payment for medical services.

ADH has known since its attempted citation of LRFPS for ultrasound and related billing in 2016 that much more than a "mere delay" is involved in its enforcement of the Payment Ban. *Cf.* ADH Br. Issues 2 & 3. Undisputed facts established at that time, like the undisputed record here, showed that providers are *never* paid for a huge fraction of ultrasound patients' care if payment is not collected at the time of service – as is standard in the practice of medicine and especially critical where there is no insurance or other third-party payment source. See Appeal, Exhs 1 and 2.[1] ADH recognized that such an asserted deficiency inappropriately interfered with medical providers' practice in 2016, yet ADH has now without rational explanation reversed course. But the same reasons that providers could not be so severely penalized in 2016 exist today. The legislature's addition of different categories of those who might bill for physicians' services does not change the fact that preventing payment for those services is unjustified. Enforcing deficiency notices and preventing payment now, when efforts to do so in 2016 were properly withdrawn, is arbitrary and capricious.

[1] The Payment Ban bears no resemblance to the workers' compensation system, A.C.A. 11-9-118, where workers who have made a claim for workers' compensation coverage can formally serve medical providers with notice to rely on that alternate payment scheme. In contrast, the Payment Ban imposes *loss* of payment on providers and no potential recourse to any source of payment other than patients themselves, rather than offering a *different* system for payment like workers' compensation insurance.

ADH's current interpretation and enforcement of the Payment Ban impermissibly interferes with the practice of medicine.

ADH does not respond to Respondents' argument and the evidence that demonstrates that ADH's current interpretation of the Payment Ban conflicts with A.C.A. §20-7-109, which forbids ADH and the Board from regulating the practice of medicine or interfering with patients employing the practitioner of their choice. The fact that an amendment to the Payment Ban provision was broadened to include not only physicians but the abortion facilities where they practice does not take away from the fact that its restriction on billing interferes with and impermissibly regulates the practice of medicine.

The deficiency citations issued to PPAEO's health centers for its collection of credit card information within the 48-hour waiting period must be withdrawn.

ADH also fails to address the substance of Respondents' argument that the collection of credit card information does not violate the Payment Ban, and that ADH's citation of PPAEO for collecting credit card information was arbitrary and capricious. Instead, ADH merely states the general legal principle that for an action to be arbitrary and capricious, the challenging party must show that the action is not supportable on any rational basis. Response, Issue 3.

But that is precisely what Respondents have done. Interpreting the Payment Ban as prohibiting the collection of credit card information violates the plain language of the statute, is in excess of the agency's statutory authority, and is arbitrary and capricious. A.C.A. § 25-15-212. As detailed in Respondents' opening brief, the plain language of the statute does not prohibit the mere collection of credit card information at the first visit: collecting credit card information does not constitute "requiring" or "obtaining" payment. *See* Appeal at 25-26. Petitioner fails to respond to this argument, perhaps because it is so clear that the collection of credit card information does not fall within the statutory prohibition.

Under Arkansas law, an agency interpretation of a statute will be overturned when it clearly conflicts with the statutory language. *See Ford v. Keith*, 338 Ark. 487, 494 (1999). Thus, "when the statute is not ambiguous, as is the case here, the court will not interpret a statute to mean anything other than what it says." *Simpson v. Cavalry SPV I, LLC*, 2014 Ark. 363, 8, 440 S.W.3d 335, 340 (2014), even if the agency takes a contrary view. Moreover, the Arkansas Supreme Court has been clear that "[c]ode provisions imposing penalties for noncompliance with licensing requirements ... must be strictly construed." *Wilcox*, 298 Ark. at 161. With statutes imposing penalties like the Payment Ban, "every doubt as to construction must be resolved in favor of the one against whom the enactment is sought to be applied." *Id.* Accordingly, since the deficiencies issued to PPAEO were based solely on the collection of credit card information at the first visit, they must be set aside.

ADH has tortuously interfered with PPAEO's contractual relations with its patients and sovereign immunity in no way precludes this challenge to the deficiency citations.

In response to respondents' tortious interference claim, ADH simply repeats its erroneous arguments that it has not acted arbitrarily and capriciously to interfere with medical providers' practice and compensation from their patients. In addition, it asserts that sovereign immunity precludes "a claim" for tortious interference with contract. *See* Response, Issue 5. Respondents are asserting tortious interference as a defense against these deficiencies. Moreover, there are no constitutional issues or just compensation issues now before the Board. Rather, it is properly being asked according to its own administrative procedures to reverse these deficiencies issued by ADH and prevent ADH's further enforcement of the Payment Ban in this manner. Any issues of takings, compensation, constitutional limits and broader remedies are for the courts, if ADH fails to set aside these deficiencies. Thus, ADH's citation to the Arkansas Constitution and

sovereign immunity is not applicable here and, again, ignores and distracts from ADH's failure to conduct itself coherently and within its limited powers.)

The Payment Ban, as currently interpreted by ADH, does not affect the rate of patient return for an abortion.

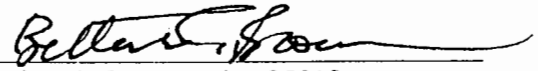
In reply to Petitioner's Issue 1(c), Respondents submit the affidavit of Mick Tilford, PhD, attached as Exhibit 3 to this Reply. Dr. Tilford's analysis of Respondents' patient data demonstrates that the Payment Ban, as currently interpreted by ADH, has no impact other than prohibiting payment for 48 hours and does not affect the likelihood that a woman will return to obtain an abortion.[2]

CONCLUSION

For the reasons asserted above, the Statements of Deficiencies should be dismissed and the Motion to Dismiss granted.

Dated: October 11, 2018

Respectfully submitted:



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[2] Dr. Tilford did not analyze the data from PPAEO since closures of PPAEo in June 2018 (due to ongoing litigation over the constitutionality of restrictions to access to abortion in Arkansas) resulted in insufficient data from PPAEO post-March 2018 for him to perform a proper analysis.

Stricken language would be deleted from and underlined language would be added to present law.
Act 383 of the Regular Session

State of Arkansas *As Engrossed: H2/10/17*
91st General Assembly **A Bill**
Regular Session, 2017 HOUSE BILL 1428

By: Representatives Lundstrum, Ballinger, Bentley, Cavenaugh, Coleman, Davis, Della Rosa, Dotson, C. Douglas, Farrer, Gates, Gonzales, Hollowell, Jett, Lowery, Lynch, McCollum, D. Meeks, Miller, Penzo, Payton, Pilkington, Richmond, Rye, B. Smith, Speaks, Warren, Watson, J. Williams
By: Senators Flippo, Bledsoe, A. Clark, B. Johnson

For An Act To Be Entitled

AN ACT TO AMEND LAWS CONCERNING UNLAWFUL ABORTIONS; TO AMEND LAWS CONCERNING THE PROCEDURE OF DENIAL, SUSPENSION, OR REVOCATION OF A HEALTH FACILITIES SERVICE LICENSE; TO AMEND THE LAWS REGARDING ABORTION CLINICS; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND LAWS CONCERNING UNLAWFUL ABORTIONS; TO AMEND LAWS CONCERNING THE PROCEDURE OF DENIAL, SUSPENSION, OR REVOCATION OF A HEALTH FACILITIES SERVICE LICENSE; AND TO AMEND THE LAWS REGARDING ABORTION CLINICS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 5-61-101 is amended to read as follows:

5-61-101. Abortion only by licensed ~~medical practitioner~~ physician.

(a) It is unlawful for any person to induce another person to have an abortion or to ~~willfully~~ knowingly terminate the pregnancy of a woman known to be pregnant with the ~~intent~~ purpose to cause fetal death unless the person is a physician licensed to practice medicine in the State of Arkansas.

(b) ~~Violation~~ A violation of subsection (a) of this section is a Class D felony.

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(c) ~~Nothing in this section shall be construed to~~ This section does not allow the charging or conviction of a woman with any criminal offense in the death of her own unborn child in utero.

SECTION 2. Arkansas Code § 20-9-302 is amended to read as follows:

20-9-302. Abortion clinics, health centers, etc.

(a)(1) A clinic, health center, or other facility in which the pregnancies of ten (10) or more women known to be pregnant are willfully terminated or aborted ~~each~~ in any month, including nonsurgical abortions, shall be licensed by the Department of Health.

(2)(A) ~~The facilities, equipment, procedures, techniques, and conditions of those clinics or similar facilities shall be subject to periodic inspection by the department~~ The department shall inspect a clinic, health center, or other facility at least annually, and inspections shall include without limitation:

(i) The facilities, equipment, and conditions of a clinic, health center, or other facility; and

(ii) A representative sample of procedures, techniques, medical records, informed consent signatures, and parental consent signatures.

(B) An inspector shall arrive at the clinic, health center, or other facility unannounced and without prior notice.

(b) The department ~~may~~ shall:

(1) ~~adopt~~ Adopt appropriate rules ~~and regulations regarding~~, including without limitation the facilities, equipment, procedures, techniques, medical records, informed consent signatures, parental consent signatures, and conditions of ~~clinics and other~~ clinics, health centers, and other facilities subject to the provisions of this section to assure at a minimum that:

(A) The ~~the~~ facilities, equipment, procedures, techniques, and conditions are aseptic and do not constitute a health hazard~~.~~; and

(B) The medical records, informed consent signatures, and parental consent signatures meet statutory requirements;

(2) Levy and collect an annual fee of five hundred dollars ($500) per facility for issuance of a permanent license to an abortion facility; and

(3)(A) Deny, suspend, or revoke licenses on any of the following grounds:

(i) The violation of any provision of law or rule; or

(ii) The permitting, aiding, or abetting of the commission of any unlawful act in connection with the operation of the institutions.

(B)(i) If the department determines to deny, suspend, or revoke a license, the department shall send to the applicant or licensee, by certified mail, a notice setting forth the particular reasons for the determination.

(ii) The denial, suspension, or revocation shall become final thirty (30) days after the mailing of the notice unless the applicant or licensee gives written notice within the thirty-day period of a desire for hearing.

(iii)(a) The department shall issue an immediate suspension of a license if an investigation or survey determines that:

(1) The applicant or licensee is in violation of any state law, rule, or regulation; and

(2) The violation or violations pose an imminent threat to the health, welfare, or safety of a patient.

(b)(1) The department shall give the applicant or licensee written notice of the immediate suspension.

(2) The suspension of the license is effective upon the receipt of the written notice.

(iv) The denial, suspension, or revocation order shall remain in effect until all violations have been corrected.

(C) The applicant or licensee shall:

(i) Be given a fair hearing; and

(ii) Have the right to present evidence as may be proper.

(D)(i) On the basis of the evidence at the hearing, the determination involved shall be affirmed or set aside.

(ii) A copy of the decision, setting forth the finding of facts and the particular grounds upon which it is based, shall be sent by certified mail to the applicant or licensee.

(iii) The decision shall become final fifteen (15) days after it is mailed unless the applicant or licensee, within the fifteen-day period, appeals the decision to the court.

(E) A full and complete record of all proceedings shall be kept and all testimony shall be reported, but it need not be transcribed unless the decision is appealed or a transcript is requested by an interested party who shall pay the cost of preparing the transcript.

(F) Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by rule.

(G) The procedure governing hearings authorized by this section shall be in accordance with rules promulgated by the department.

~~(c) The department may levy and collect an annual fee of five hundred dollars ($500) per facility for issuance of a permanent license to an abortion facility.~~

~~(d)~~(c)(1) Applicants for a license shall file applications upon such forms as are prescribed by the department.

(2) A license shall be issued only for the premises and persons in the application and shall not be transferable.

~~(e)~~(d)(1) A license shall be effective on a calendar-year basis and shall expire on December 31 of each calendar year.

(2) Applications for annual license renewal shall be postmarked no later than January 2 of the succeeding calendar year.

(3) License applications for existing institutions received after that date shall be subject to a penalty of two dollars ($2.00) per day for each day after January 2.

~~(f)~~(e) Subject to such rules and regulations as may be implemented by the Chief Fiscal Officer of the State, the disbursing officer for the department may transfer all unexpended funds relative to the abortion clinics that pertain to fees collected, as certified by the Chief Fiscal Officer of the State, to be carried forward and made available for expenditures for the same purpose for any following fiscal year.

~~(g)~~(f) All fees levied and collected under this section are special revenues and shall be deposited into the State Treasury~~, there~~ to be credited to the Public Health Fund.

SECTION 3. Arkansas Code § 20-16-1703(d), concerning the informed

consent requirement within the Woman's Right-to-Know Act, is amended to read as follows:

(d) A physician, facility, employee or volunteer of a facility, or any other person or entity shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section.

/s/Lundstrum

APPROVED: 03/06/2017

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH — PETITIONER

V.

LITTLE ROCK FAMILY PLANNING SERVICES
PLANNED PARENTHOOD OF
ARKANSAS AND EASTERN OKLAHOMA dba
PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

Supplementary Affidavit of Lori Williams

My name is Lori Williams. I am over the age of 21, competent and have personal knowledge of the matters testified to herein. I submit this supplementary affidavit in the captioned matter.

1. On November 21, 2017, the Arkansas Department of Health conducted an inspection of Little Rock Family Planning Services' clinic. On December 7, 2017, it issued a letter stating that "the Red Cross was not listed on the Emergency Phone Number list as required." See December 7, 2017 letter from Beck Bennett, attached as Exh. 1. There was no deficiency citation issued for charging patients at the time of their first visit to LRFPS for an ultrasound and other services related to abortion care.

2. I reviewed the records of Little Rock Family Planning Services ("LRFPS") to determine the number of patients who visited the facility from March 2017 through August 2018 making inquiry about an abortion by month. Of those patients, I also determined the number of

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women who returned for an abortion during the same period of time, also by month. The results of my review are below. [1]

LRFPS Abortion/Ultrasound Data

2017	Abortions	Ultrasounds (No Shows)	Total Patients
March	273	25	298
April	193	11	204
May	204	9	213
June	211	17	229
July	194	15	209
August	176	17	193
September	194	26	220
October	151	23	174
November	162	13	175
December	201	13	214

2018

January	182	22	204
February	226	16	242
March 1-15			
After Stopped Charging for Ultrasound At First Visit			
March 2-16	151	18	169

[1] Note that a patient may have had her first visit for an ultrasound and related services in one month and her abortion in a later month.

April	164	18	182
May	220	15	235
June	231	20	249
July	144	18	162
August	173	19	191

3. I am providing updated information since the date of my initial affidavit. Since March 14, 2018, the day after receipt of the Statement of Deficiencies to the date of this supplementary affidavit, 108 patients, who did not return for an abortion, were billed. Of these 10 patients have paid for their ultrasound and other services after receiving a bill. This has resulted in a total loss of $ 19,600 to LRFPS and Dr. Tvedten over this period. This loss will increase so long as § 20-16-1703(d) is in effect.

18. In addition to the loss of revenue from patients, LRFPS incurs additional expense in staff time for billing and efforts to obtain payment from patients for services rendered. These additional staff expenses would be unnecessary if § 20-16-1703(d) were not in effect as now interpreted by ADH. These additional expenses are $720.00 for 40 additional hours of staff time. These additional staff expenses will increase as long as this law is in effect. Thus, the total loss to LRFPS from March 14, 2018 to the date of this supplementary affidavit is $20,320.00.

FURTHER AFFIANT SAYETH NOT

Lori Williams

State of Arkansas

County of Pulaski

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 10/6/22

(Seal or Stamp)

BRITTNEY CAMP
MY COMMISSION # 12389627
EXPIRES: October 6, 2022
Pulaski County

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and

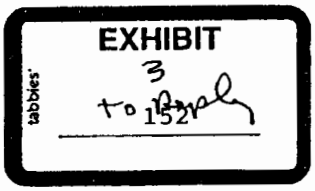
PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

AFFIDAVIT OF J. Mick Tilford, PhD

1. I am a Professor and Chair of Health Policy and Management in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences. I previously served as the Director of the Ph.D. program in Health Systems and Services Research at UAMS. I am a health economist with over 30 years of experience in this field. A copy of my curriculum vitae is attached hereto as Exhibit 1.

2. I submit this affidavit on behalf of Little Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma ("PPAEO") in the above-captioned matter.

3. I was asked to provide a statistical analysis of Ark. Code Ann. § 20-16-1703(d). and its effect on patient behavior -- more specifically to investigate whether a 48-hour or delay in payment for services provided at a women's initial visit reduces the rate at which women return for an abortion. The law states that "A physician shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the forty-eight-hour reflection period required in this section."



4. In analyzing the effect of this law, I relied on information about patient visits provided by LRFPS and data contained in the affidavit and supplementary affidavit of Lori Williams. I used all the data contained in William's supplementary affidavit. According to the information provided, at a woman's initial visit to the LRFPS clinic, she is given an ultrasound, provided with state-mandated information and materials, and if she indicates a desire to proceed with an abortion and is eligible to do so, undergoes informed-consent counselling. She is also scheduled for a procedure that occurs following the mandated waiting 48-hour waiting period.

5. I understand that before the Statement of Deficiencies was received by LRFPS on March 14, 2018, LRFPS collected payment for services provided at the first visit at that visit. I understand that after the Statement of Deficiencies was received, LRFPS ceased collecting payment for services provided at the first visit until at least 48 hours had passed.

6. To evaluate whether this change in payment practices impacted the likelihood of a woman obtaining an abortion, I compared data from before and after the Statement of Deficiencies was received by LRFPS.

7. To perform a statistical analysis, data were provided from LRFPS on women who made an initial visit to an abortion provider both before and after the Statement of Deficiencies was received. The analysis compares the percentage of women that returned for an abortion in these pre and post periods. Because LRFPS stopped accepting payment from women at the initial visit the day after receiving a deficiency citation from ADH on March 14, 2018, data from the second half of March is included in the analysis as the post-policy period for LRFPS. To address this data issue, the analysis was repeated with the month of March, 2018, excluded. The initial test of significance is based on a t-test under the hypothesis that the percentage of return visits is reduced due to the law's prohibition on charging for initial visit services until the lapse of at least

48 hours. This analysis does not control for trend. If return visits are trending upward or downward, simple pre-post comparisons provide misleading estimates as the analysis captures the influence of trend and the change in LRFPS' practice. Therefore, I have done an analysis that does control for trend, reflected in Table 3.

8. Table 1 provides an analysis of the mean return rate before and after the LRFPS' change in practice went into effect in March of 2018. The percentage of women returning for an abortion stayed approximately constant in this analysis with 91.88% returning in the period prior to the policy compared to 90.76% in the period after the policy. The difference in rates for the pre and post Statement of Deficiencies periods for the LRFPS is positive and small, leading to an insignificant finding which supports the conclusion that whether payment is required at the first visit, or payment obtained until after the lapse of 48 hours, has no effect on a woman's decision to return for an abortion.

Table 1. Before and After Comparison Using All Data Points

Statistic	Percentage Returning	Std. Err.
Mean (Before Policy)	91.88%	0.008
Mean (After Policy)	90.76%	0.007
Difference	0.0112	0.012
t-value	0.9267	
p-value	0.1839	

9. Table 2 provides a similar analysis with the exception that the month of March is excluded. In this analysis, the percentage of women returning for an abortion remains similar.

with less than a 1 percentage point reduction in the months following the policy. The small difference in the percentage returning is not significant ($p = 0.2663$) at conventional levels ($p = 0.05$) and the hypothesis that the policy led to a reduction in return visits would not be supported.

Table 2. Before and After Comparison Using All Data Points Except March 2018

Statistic	Percentage Returning	Std. Err.
Mean (Before Policy)	91.88%	0.008
Mean (After Policy)	91.04%	0.008
Difference	0.008	0.013
t-value	0.6388	
p-value	0.2663	

10. Table 3 provides results from an ordinary least squares (OLS) regression analysis that allows for trends in return visits to be controlled. OLS regression is a standard statistical technique often referred to as multiple regression in that it allows for an analysis of a dependent variable (percentage of women returning) in relation to several independent variables (trend and policy period). In multiple regression, the effect of the policy period is estimated holding trend constant or controlling for trend. All of the data points were used in this analysis. The trend variable was negative suggesting that return visits were trending down over the study period, but the variable was not significant. If return visits were trending down, a pre-post analysis would indicate a decline in return visits even in absence of the law. After controlling for trend, the estimate of the policy effect was positive with almost a 1 percentage point increase in return

visits after LRFPS' change in practice. . However, the test of significance was again not supported (failed to reject the null hypothesis by not reaching conventional p-values for significance such as 0.05) suggesting that the law had no effect on return visits.

Table 3. Before and After Comparison Using All Data Points and Accounting for Trend

Statistic	Coefficient	Std. Err.	t-value	p-value
Trend Variable	-0.002	0.002	-1.01	0.328
Pre/Post Dummy	0.008	0.022	0.36	0.725
R^2	0.112			

11. Table 4 provides results from another ordinary least squares regression analysis that excludes the month of March. Again, the trend variable is negative, similar in magnitude and statistically insignificant. The estimate of the change in LRFPS' practice was positive in this analysis, but still small and statistically insignificant. This analysis also suggests that the policy had no effect on return visits.

Table 4. Before and After Comparison Using All Data Points Except March and Accounting for Trend

Statistic	Coefficient	Std. Err.	t-value	p-value
Trend Variable	-0.002	0.002	-1.17	0.262
Pre/Post Dummy	0.016	0.024	0.65	0.529
R^2	0.113			

12. Using standard statistical analysis, I find no evidence that the rate of return visits changed due to LRFPS' change in practice. Based on the data and economic analysis, the prohibition on

payment for a 48-hour period after for the initial visit has no impact on whether or not a woman returns for an abortion. The percentage of women that made an initial visit and then returned for an abortion is approximately 91% and this percentage did not change over the pre and post periods studied. The finding holds based on simple statistical tests of differences and after controlling for trend.

FURTHER AFFIANT SAYETH NOT

J. Mick Tilford

State of Arkansas
County of Pulaski

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: (Seal or Stamp)

CURRICULUM VITAE

John (Mick) Tilford, Ph.D.
Professor and Chair
Fay W. Boozman College of Public Health
University of Arkansas for Medical Sciences

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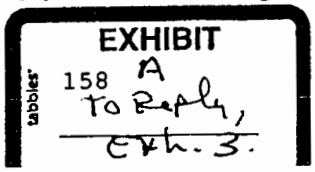
I. BIOSKETCH AND PROFESSIONAL ACCOMPLISHMENTS

John "Mick" Tilford currently serves as a Professor and Chair of Health Policy and Management in the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences. Dr. Tilford also served as the Director of the Ph.D. program in Health Systems and Services Research at UAMS from 2012-2015. He has a secondary appointment in the Division of Pharmaceutical Evaluation and Policy in the College of Pharmacy and an appointment as a Senior Analyst at the Arkansas Foundation for Medical Care to assist with program evaluation. Dr. Tilford teaches courses in health economics and variations in health system performance to students in PhD and master's level programs. His research program focuses on methods for the economic evaluation of health services. He has studied the cost-effectiveness of improving outcomes in children with traumatic brain injuries, quality of care associated with intensive care units, and quality-adjusted life years in children with chronic conditions, especially children with autism. A recent area of interest has been the development of methods for incorporating family effects in economic evaluations. He received his Ph.D. in health economics from Wayne State University (1993) with the assistance of a dissertation grant from the Agency for Health Care Policy and Research (now AHRQ).

As the Chair for the Department of Health Policy and Management, Dr. Tilford worked to improve the educational programs within the department. The PhD program in Health Systems and Services Research changed from a part-time program to a full time program admitting at least two students per year with stipends. The increase in PhD students led to an increase in the number of grant submissions by faculty and publications by students and faculty.

The MHA program (under the direction of Steve Bowman initially and now Rick Ault) changed dramatically by focusing on integrating the program with the UAMS clinical enterprise and other health systems in the state. Dr. Tilford negotiated a fellowship position with the UAMS hospital CEO that led to a large increase in fellowship placements throughout the enterprise. The program



has placed students in all of the major health systems in central Arkansas including Baptist Health System and Saint Vincent Infirmary. Through these placements and strategic plans to integrate teaching and clinical activities, student performance increased markedly as witnessed by the increase in students being placed in nationally competitive fellowships including the Cleveland Clinic, Houston Methodist Hospital, the American College of Healthcare Executives, and Arkansas Children's Hospital. Enrollment in the MHA program has grown with record cohorts being admitted in recent years.

To improve the MPH program, Dr. Tilford expanded the types of preceptorships available to students. Students in the MPH program have been placed to work on implementing patient-centered medical homes through the Arkansas Medicaid program, implementing provider led payment reform through the Arkansas Department of Human Services, implementing traumatic brain injury surveillance programs within the Arkansas Spinal Cord Commission and most recently, working on implementing new personnel systems in the UAMS department of human resources.

Dr. Tilford and Mr. Ault led the development of a collaboration with the Walton College of Business at the University of Arkansas to create a healthcare track within their Executive MBA program. The first cohort of students started in the summer of 2017. He has received approval from the Arkansas Department of Higher Education to create a certificate program in analytics to start in the fall of 2018.

II. EDUCATION

Ph.D.	Economics	Wayne State University	1993
M.A.	Economics	Central Michigan University	1985
B.S.	Business & Economics	Central Michigan University	1982

Major Field: Health Economics.
Minor Field: Industrial Organization.

III. ACADEMIC AND PROFESSIONAL POSITIONS

2013 - present	Chair, Department of Health Policy and Management, Fay W. Boozman College of Public Health, University of Arkansas for Medical Sciences.
2012 - 2015	Director, Doctor of Philosophy in Health Systems Research Program, College of Public Health, University of Arkansas for Medical Sciences.
2014 - 2015	Leadership Council, Translational Education Center of the Translational Research Institute, University of Arkansas for Medical Sciences.
2011 - 2014	Co-Director, Comparative Effectiveness Research Component of the Translational Research Institute, University of Arkansas for Medical Sciences.

2010 – present	Professor. Department of Health Policy and Management. College of Public Health. University of Arkansas for Medical Sciences (Primary Appointment as of 6/09).
2014 – present	Professor. Division of Pharmaceutical Evaluation and Policy. College of Pharmacy. University of Arkansas for Medical Sciences (Secondary Appointment).
2009 – 2014	Associate Professor. Division of Pharmaceutical Evaluation and Policy. College of Pharmacy. University of Arkansas for Medical Sciences (Secondary Appointment).
2008 – present	Senior Analyst, Arkansas Foundation for Medical Care, Little Rock, Arkansas.
2002 – 2010	Associate Professor, Department of Health Policy and Management, College of Public Health. University of Arkansas for Medical Sciences (Primary Appointment as of 6/09).
2000 – 2009	Associate Professor, Department of Pediatrics. University of Arkansas for Medical Sciences.
2002 – 2005	Faculty (part time). Department of Health Services Administration. University of Arkansas - Little Rock.
1999 – present	Graduate Faculty, University of Arkansas for Medical Sciences. Division of Biometry.
1994 – 2000	Assistant Professor. Department of Pediatrics. University of Arkansas for Medical Sciences.
1993 – 1994	Instructor, Department of Pediatrics, University of Arkansas for Medical Sciences.
1988 – 1992	Graduate Research Assistant. Department of Economics. Wayne State University.
1986 – 1988	Graduate Assistant. Department of Economics. Wayne State University.
1985 – 1986	Instructor, Department of Economics. University of Minnesota – Duluth.
1983 – 1985	Graduate Assistant, Department of Economics. Central Michigan University.
1982 – 1983	Instructor. Jackson Community College (State Prison of Southern Michigan).

IV. FUNDED RESEARCH AND CONTRACTS

A. Currently Active Research

1. Centers for Disease Control and Prevention. "Arkansas Prevention Research Center for Cardiovascular Risk (HTN) Reduction. Entire Period of Support 9/30/2014-9/29/2019.

2. National Institutes of Health, National Center on Minority Health Disparities. "Weight Loss and Maintenance for Rural. African American Communities of Faith (The WORD)." Co-Investigator with 5% effort (K. Yeary, PI). Entire period of support 9/12 – 8/17.

B. Currently Active Contracts

1. Arkansas Center for Health Improvement. "Evaluation of the Arkansas Medicaid Expansion through the Private Option." (Joseph Thompson, PI). Entire Period of Support 9/14-8/19.

C. Completed Research and Contracts

1. Healogics. "Evaluation of Prior Authorization Rules on the Use of Hyperbaric Oxygenation and Outcomes for Patients with Severe Leg Wounds." Principal Investigator. Entire period of support 6/17 – 8/17.

2. National Institute of Mental Health, "Mapping Clinical Outcomes to Preference-based Measures from the NDAR Database." Co-Investigator and Mentor (N Payakachat, PI). Entire period of support: 1/14-12/15.

3. Arkansas Insurance Department. "Evaluation of the Arkansas Marketplace Health Insurance Exchange." Principal Investigator. Entire Period of Support 1/14 – 6/15.

4. National Institutes of Health, "Remote Food Photography for the Real-time Measurement of Children's Food Intake," Co-Investigator with 6% effort (C. Martin, PI). Entire period of support 4/11-3/12.

5. National Institutes of Health, "Arkansas Center for Clinical and Translational Research." Co-Director of Translational Education Component with 10% effort (L. James and C. Beck, PIs). Entire period of support 9/11 – 3/15.

6. National Institutes of Health, "Reducing Asthma Disparities through School-Based Telemedicine for Rural Children." Co-Investigator with 5% effort (Tamara Perry, PI). Entire period of support 6/10 – 5/14.

7. Centers for Disease Control and Prevention, "Enhanced Academic Detailing to Increase Immunization Recall Rates," Co-Investigator with 5% effort (J. Gary Wheeler, PI). Entire period of support 9/10-8/14.

8. Arkansas Minority Health Commission. "Economic Cost of Racial and Ethnic Health Disparities." Principal Investigator. Entire period of support 9/13 – 4/14.

9. Arkansas Spinal Cord Commission. "Post-Acute Care Costs for Brain Injuries, Spinal Cord Injuries, and Amputations in Arkansas." Principal Investigator using Arkansas Foundation for Medical Care. Entire period of support 7/12 – 6/13.

10. National Institute of Mental Health, "Measuring Quality Adjusted Life Years in Children with Autism Spectrum Disorders." Principal Investigator with 40% effort (Karen Kuhlthau, Co-PI). Entire period of support: 9/09-8/12. Total Amount: $889,603.

11. National Institute of Mental Health, "Measuring Quality Adjusted Life Years in Children with Autism Spectrum Disorders - Supplement," Principal Investigator with 5% effort (Karen Kuhlthau, Co-PI). Entire period of support: 6/10-5/12. Total Amount: $89,708.

12. Arkansas Department of Human Services. Division of Aging and Adult Services. Contract to Assess Balancing Incentives associated with the Accountable Care Act. Principal Investigator with 10% effort. Entire period of support 1/12 – 6/12.

13. National Institute of Drug Abuse, "Development and Efficacy Test of Computerized Treatment for Marijuana Dependence," Co-Investigator with 5% effort (Alan Budney, PI). Entire period of support 7/10 – 6/12.

14. National Institute on Alcohol Abuse and Alcoholism, "Family Based Contingency Management for Adolescent Alcohol Abuse," Co-Investigator with 5% effort (Cathy Stanger, PI). Entire period of support 7/07 – 6/11.

15. National Institute of Drug Abuse, "Behavioral treatment of Adolescent Marijuana Abuse," Competing Continuation for R01-DA15186, Co-Investigator with 5% effort (Alan Budney, PI). Entire period of support 7/07 – 6/10.

16. Center for Clinical and Translational Research, University of Arkansas for Medical Sciences, "Clinical Indicators to Inform Clinicians' Referral Decisions for Cardiovascular Evaluation in Women." Co-Investigator with 1% contributed effort, (Jean McSweeney, PI).

17. Arkansas Biosciences Institute, "Center of Excellence in Child Health Services Research," Co-investigator with 5% effort (James Robbins, PI). Entire period of support 7/07 – 6/08. The objective of this study was to create a central resource for investigators in the department of pediatrics to use in order to advance child health services research.

18. Children's University Medical Group, "A Hospital Data Resource and Analysis Center," Principal Investigator with no effort. This intramural project provided funds to support projects using the Healthcare Cost and Utilization Project (HCUP) database with faculty and fellows in the department of pediatrics.

19. Arkansas Children's Hospital, "Office of Health Care Research." Co-Investigator with 20% effort. (James Robbins, PI). Entire period of support: 6/94 – 6/09. The objective of this program was to provide services to ACH for the analysis of quality improvement projects.

20. Centers for Disease Control and Prevention – AAMC. "Using the HCUP Databases to Study Birth Defects." Co-investigator with 15% effort. (James Robbins, PI). Entire

period of support 10/03 – 8/07. The objectives of this study were to evaluate the birth incidence, cost, and outcomes of children born with birth defects.

21. Children's Sentinel Nutrition Project, "Cost Analysis for Hospitalizations." Co-Investigator with 5% effort (James Robbins, PI). Entire period of support 2/07 – 8/07. This small study provided support to assess whether children with food insecurity were associated with increased costs of hospitalization.

22. Centers for Disease Control and Prevention, "Health State Preference Scores and Productivity Costs for Caregivers of Children with Craniofacial Anomalies." Principal Investigator with 15% effort. Supplement to "Cooperative Agreement to Establish a Center of Excellence in Birth Defect Prevention," (Charlotte Hobbs, PI). Entire period of support 8/05 – 9/07. This project compared methods for incorporating caregiver impacts in economic evaluations of interventions to prevent or treat craniofacial birth defects.

23. Families USA (Contract). "Hospitalizations of Uninsured Children." Principal Investigator with 15% effort. Entire period of support 3/06 – 12/06. This study was the first contract received after creating a hospital data resource and analysis center. The objective was to compare outcomes of hospitalized children that lacked health insurance. A policy brief based on the study was produced by Families USA. Findings from the study were used on the US Senate floor to defend the continuation of the S-CHIP program.

24. Centers for Disease Control and Prevention – AAMC. "Health Effects of Congenital Hearing Loss in Children," Principal Investigator with 15% effort. Entire period of support 10/03 – 9/06. The purpose of this study was to generate data on quality adjusted life years in a cohort of children with hearing loss that were diagnosed prior to the advent of universal newborn hearing screening. This is the only data on QALYS in children with hearing loss in the US prior to universal newborn screening. Future research may investigate whether QALY relationships have changed following the introduction of universal newborn hearing screening.

25. Maternal and Child Health Bureau (HRSA). "Economic Evaluation of Intensive Care Services for Pediatric Traumatic Brain Injury Patients," Principal Investigator with 40% effort. Entire period of support 3/01 – 2/05. The purpose of this study was to conduct a cost-effectiveness analysis of technological change in the treatment of traumatic brain injury. HCUP data were used to generate an estimate of survival change associated with improved technology. QALY data and other cost data were collected from 10 pediatric intensive care units located across the country. The project received a national hero's award from the Emergency Medical Services for Children program.

26. Centers for Disease Control and Prevention. (DHHS) "Cooperative Agreement to Establish a Center of Excellence in Birth Defect Prevention." Co-Investigator with 15% effort. (Charlotte Hobbs, PI). Entire period of support: 10/97 –10/03. This grant established a large case-control study of birth defects. The study included a health services team to study costs and outcomes of birth defects.

27. University of California - Los Angeles. "Cost Analysis for Care of Children in the Emergency Department: Guidelines for Preparedness." Subcontract with 10% effort. Entire period of support 2/02 – 12/02. This subcontract was awarded to develop cost estimates associated with preparedness for pediatric emergencies.

28. DHHS – Arkansas. "Evaluation of the Family Planning Waiver," Co-Investigator with 5% effort. Entire period of support 3/01 – 12/04. My role on this study was to set up a system to calculate budget impacts of the family planning waiver.

29. Agency for Healthcare Research and Quality, (DHHS) "Developing an Asthma Management Model for Head Start Children," Co-Investigator with 10% effort. (Perla Vargas, PI). Entire period of support: 9/00 –8/03. This randomized controlled trial examined a case management model in young children. My role was to evaluate the costs of the intervention.

30. Agency for Health Care Policy and Research, (DHHS), R01 HS09055, "Quality and Cost Containment in Pediatric Intensive Care," Principal Investigator with 35% effort. (Debra Fiser, Co-PI). Entire period of support: 9/95 – 8/99. (Funded on initial submission). This study addressed the question of whether race or insurance influenced the allocation of pediatric intensive care services. The study collected data on over 5,000 subjects from pediatric intensive care units located nationally. We found significant differences in treatment and outcome by insurance, but not by race. Findings from the study also were used in the development of guidelines for the management of pediatric traumatic brain injury.

31. Agency for Health Care Policy and Research, (DHHS), R01 HS09055, "Quality and Cost Containment in Pediatric Intensive Care – Administrative Supplement," Principal Investigator with 5% effort. (Al Torres, Co-PI). Entire period of support: 4/97 – 9/99. The supplement was awarded to extend analysis of intensive care unit cost and outcomes to the hospital setting.

32. Maternal and Child Health Bureau – Health Resources and Services Agency, (DHHS), "Outcomes Assessment in Pediatric Trauma Patients," Co-Investigator with 5% effort. (Mary Aitken, PI). Entire period of support: 9/97 – 8/99. This study examined outcomes of children following injury.

33. Office of Rural Health Policy – Health Resources and Services Agency, (DHHS), "Arkansas Telehealth: Taking the Distance out of Caring," Co-Investigator with 15% effort. (Ann Bynum, PI). Entire period of support: 9/97 – 9/99. This study was a federal initiative to evaluate telemedicine services. My role in the project was to direct the local evaluation.

34. American Association for Respiratory Care, "Respiratory Care Practitioner-Controlled Ventilator Weaning of Children." Co-Investigator with 5% effort. (Submitted with Al Torres, PI. Directed with Mark Heulitt, PI). Entire period of support: 7/98 – 6/99. This project was a randomized controlled trial to test whether the use of respiratory care

practitioners were better able to assess weaning from mechanical ventilation and reduce the amount of time on the ventilator and the length of stay in the hospital.

35. Housing and Urban Development, "Get Smart: Health Insurance in the Delta," Co-Investigator with 20% effort. (James Robbins, Director of Evaluation). Entire period of support: 9/93 – 1/97. This project received funds to provide health insurance to previously uninsured children in the Mississippi delta.

36. Rural Utilities Service – Department of Commerce, "Arkansas Rural Medlink," Co-investigator with 20% effort. (Charles Cranford, PI). Entire period of support: 5/95 – 4/96. Served as the evaluator for this project that sought to increase access to telemedicine in rural Arkansas.

37. MCPG/CUMG research fund. "Estimation of Offset Effects Between Prescription Drug Use and Expenditures on Hospital and Ambulatory Care Visits," Co-Principal Investigator. (James Robbins, Co-PI). Entire period of support 3/95 – 4/96. This internally funded study examined whether prescription drug offsets could be estimated from the National Medical Expenditure Survey.

38. Michigan Health Care Education and Research Foundation, Grant No. 087-SAP/92-09. "Cigarette Smoking Behavior and Potential Health Care Savings in the State of Michigan," Principal Investigator. Entire period of support: 9/92 – 5/93. This grant was secured as a graduate student to estimate expenditure functions for a statistical person. It was completed while writing my dissertation.

39. Agency for Health Care Policy and Research, R03 HS07554 "Access to Medical Care and the Demand for Medical Care," Principal Investigator with 100% effort (Dissertation Grant). Entire period of support: 9/92 – 11/93.

Total Funding as Principal Investigator is approximately $4,250,000 as of 1/1/14.

D. Submitted and In-preparation Research Proposals

1. American Heart Association, "Comparative Effectiveness of Workplace Wellness Programs," Principal Investigator. Entire period of support: 1/13 – 12/14. Not Funded.

2. National Institutes of Health, "Center of Excellence Network for Comparative Effectiveness Research in Autism Spectrum Disorders," Co-Principal Investigator (with Karen Kuhlthau). Entire period of support: 7/12 – 6/17. Not Funded

3. National Institutes of Health, "Incentives and Motivational Therapy for Teens with Poorly Controlled Type 1 Diabetes," Co-Investigator (C. Stanger, PI). Entire period of support: 7/12 – 6/17. Not Funded

V. TRAINING GRANTS

A. Funded Training Grants

1. MCPG/CUMG research fund. "Research Skills Course." Principal Investigator. (Paula Roberson, Co-PI). Entire period of support: 7/96 – 6/98. This project used internal funding to provide a course to junior faculty and fellows on research skills.

2. Glaxo Inc. "Educational Grant for the Creation of a Research Skills Course." Co-Principal Investigator. (Paula Roberson, Co-PI). Entire period of support 2/94 – 5/94. This industry sponsored grant was used to fund the Research Skills Course that was given to fellow and junior faculty before the creation of the COPH.

B. Submitted Training Grants

1. Agency for Healthcare Research and Quality. "Arkansas Patient Centered Outcomes Research Scholars Program." Principal Investigator. Entire period of support 1/14-12/19. This application seeks to create a K12 institutional training program in comparative effectiveness research using patient centered outcomes. Not Funded.

VI. PUBLICATIONS

A. Peer Reviewed Journal Publications

1. Hsueh-Fen Chen, **J. Mick Tilford**, Fei Wan, Robert Schuldt. "CMS HCC Risk Scores and Home Health Patient-Experience Measures." Forthcoming in the *American Journal of Managed Care*.

2. Michael Preston, Glen Mays, Zoran Bursac, Billy Thomas, Jonathan Laryea, **J. Mick Tilford**, Michelle Odlum, Sharla Smith, Ronda Henry-Tillman. "Insurance Coverage Mandates: Impact of Physician Utilization in Moderating Colorectal Cancer Screening Rates." *American Journal of Surgery*. Epub 2018 March.

3. Clare C. Brown, **J. Mick Tilford**, T. Mac Bird. "Improved Health and Insurance Status among Cigarette Smokers After Medicaid Expansion: 2011-2016." *Public Health Reports*. Epub 2018 Jan.

4. Marcia A. Byers, Patricia Wright, **J. Mick Tilford**, Lynn S. Nemeth, Ellyn Matthews, Anita Mitchell. "Comparing Smoking Cessation Outcomes in Nurse-led and Physician-led Primary Care Visits." *J Nurs Care Qual*. 2017. EPub 2017 Sep 29.

5. Payakachat N, **J. Mick Tilford**, Kuhlthau K. "Parent-reported Use of interventions by toddlers and preschoolers with autism spectrum disorder." *Psychiatric Services*. Epub 2017 Oct 16.

6. Hsueh-Fen Chen, Saleema Karim, Fei Wan, Adrienne Nevola, Michael E. Morris, T. Mac Bird, **J. Mick Tilford**. "Financial Performance of Hospitals in the Mississippi Delta Region

under the Hospital Readmission Reduction Program and Hospital Value-based Purchasing Program. *Medical Care*. 2017 55(11): 924-930.

7. Hsueh-Fen Chen, Adrienne Nevola, Tommy M. Bird, Saleema A. Karim, Michael E. Morris, Fei Wan, **J. Mick Tilford**. "Understanding Factors Associated with Readmission Disparities among Delta Region, Delta State, and Other Hospitals." Forthcoming in the *American Journal of Managed Care*.

8. Leanne M Redman, L. Anne Gilmore, Jeffrey Breaux, Diana M Thomas, KarenElkind-Hirsch, Tiffany Stewart, Daniel S Hsia, Jeffrey Burton, John W Apolzan, Loren E Cain, Abby D Altazan, Shelly Ragusa, Heather Brady, AllisonDavis, **J. Mick Tilford**, Elizabeth F Sutton, Corby K Martin. "A novel e-Health intervention can deliver an intensive lifestyle intervention to pregnant women with pre-pregnancy overweight and obesity for management of gestational weight gain: a randomized controlled pilot study." *JMIR Mhealth Uhealth*. 2017 5(9): e133.

9. Kristina L. Bondurant, J. Gary Wheeler, Zoran Bursac, Tereasa Holmes, **J. Mick Tilford**. "Comparison of Office-Based Versus Outsourced Immunization Recall Services." *Clinical Pediatrics*, 2017 Jun;56(6):555-563.

10. Pratik Doshi1, **J. Mick Tilford**, Songthip Ounpraseuth, Dennis Z. Kuo, Nalin Payakachat. "Do Insurance Mandates Affect Racial Disparities in Outcomes for Children with Autism?" *Matern Child Health J*. 2017 Feb;21(2):351-366

11. Alesia Ferguson, Christopher Yates, **J. Mick Tilford**. "Value Based Insurance Designs in the Treatment of Mental Health Disease." *American Journal of Managed Care*. 2016 Jan 1;22(1):e38-44

12. Scott D. Grosse, Robert J Berry, **J Mick Tilford**, James E Kucik, Norman J Waitzman. "Retrospective Assessment of the Cost Savings of Prevention: Folic Acid Fortification and Spina Bifida in the United States." *American Journal of Preventive Medicine*. 2016 May;50(5 Suppl 1):S74-80

13. Nalin Payakachat, **J. Mick Tilford**, Wendy Ungar. "National Database for Autism Research (NDAR): Big data opportunities for health services research and technology assessment." *Pharmacoeconomics*. 2016 Feb;34(2):127-38.

14. **J. Mick Tilford**, Nalin Payakachat, Karen Kuhlthau, Jeffrey M. Pyne, Erica Kovacs, Jayne Bellando, D. Keith Williams, Werner Brouwer, Richard Frye. "Treatment for Sleep Problems in Children with Autism and Caregiver Spillover Effects." *Journal of Autism and Developmental Disorders*. 2015 Nov;45(11):3613-23.

15. Nalin Payakachat, **J. Mick Tilford** "Can The EQ-5D Detect Meaningful Change? A Systematic Review" *Pharmacoeconomics*. 2015 Nov;33(11):1137-54.

16. Sharla Smith, Glen Mays, **J. Mick Tilford**, Holly Felix, Geoff Curran, Michael Preston. Impact of Economic Constraints on Public Health Delivery System Structures. *AM J Pub Health*. 2015 Sep;105(9):e48-53

17. Alan J. Budney, Catherine Stanger, **J. Mick Tilford**, Pamela C. Brown, Zhongze Li, Zhigang Li, and Denise Walker. "Computer-assisted Behavioral Therapy and Contingency Management for Cannabis Use Disorder." *Psychology of Addictive Behaviors*. 2015 Sep:29(3):501-11.

18. **J. Mick Tilford** and Nalin Payakachat, "Progress in Measuring Family Spillover Effects for Economic Evaluations." Expert Reviews in Pharmacoeconomics and Outcomes Research. 2015 Apr;15(2):195-8.

    Cited in Chapter 7 of the 2nd US Panel recommendations for conducting CEA.

19. Barbara S. Saunders, **J. Mick Tilford**, Jill J. Fussell, Eldon G. Schulz, Patrick H. Casey and Dennis Z. Kuo. "Financial and Employment Impact of Intellectual Disability on Families of Children with Autism." *Families, Systems, and Health*. 2015 Mar;33(1):36-45.

20. Karen Hye-cheon Kim, Carol Cornell, T Elaine Prewitt, Zoran Bursac, **J. Mick Tilford**, Jerome Turner, Kenya Eddings, Sharhonda Love, Kimberly Harris. The WORD (Wholeness, Oneness, Righteousness, Deliverance): Design of a randomized controlled trial testing the effectiveness of an evidence-based weight loss and maintenance intervention translated for a faith-based, rural, African American population using a community-based participatory approach. *Contemporary Clinical Trials*. 2015 Jan;40:63-73.

21. Nalin Payakachat, **J. Mick Tilford**, Karen A. Kuhlthau, N. Job van Exel, Erica Kovacs, Jayne Bellando, Jeffrey M. Pyne, Werner BF Brouwer. "Predicting Health Utilities for Children with Autism Spectrum Disorders." *Autism Research*. 2014 Dec;7(6):649-63.

22. Karen Kuhlthau, Nalin Payakachat, Jennifer Delahaye, Jill Hurson, Jeffrey M. Pyne, Erica Kovacs, and **J. Mick Tilford**. "Quality of Life for Parents of Children with Autism Spectrum Disorder for Use in Cost-effectiveness Evaluations." *Research on Autism Spectrum Disorders*. 2014 Oct; (8)10:1339–1350

23. Renske Hoefman, Nalin Payakachat, Job van Exel, Karen Kuhlthau, Jeffrey Pyne, and **J. Mick Tilford**. "Caring for a Child with Autism Spectrum Disorder and Parents' Quality of Life: Application of the CarerQol." *Journal of Autism and Developmental Disorders*. 2014 Aug;44(8):1933-45.

24. Priya Mendiratta, Parthak Prodhan, **J. Mick Tilford**, and Jeanne Wei. "Trends in Percutaneous Endoscopic Gastrostomy Placement in the Elderly from 1993-2003." *American Journal of Alzheimers Disease & Other Dementias*. 2012 Dec; 27(8): 609-613.

25. Nalin Payakachat, **J. Mick Tilford**, Erica Kovacs, Karen Kuhlthau. "Autism Spectrum Disorders: A Review of Measures for Clinical, Health Services, and Cost-Effectiveness

Applications." *Expert Reviews of Pharmacoeconomics and Outcomes Research*, 2012 Aug;12(4):485-503.

26. **J. Mick Tilford**, Nalin Payakachat, Erica Kovacs, Jeffrey M. Pyne, Werner Brouwer, Todd Nick, Jayne Bellando, Karen Kuhlthau. "Preference-based Health-related Quality of Life Outcomes in Children with Autism Spectrum Disorders: A Comparison of Generic Instruments." *Pharmacoeconomics*, 2012 Aug 1; 30(8): 661–679..

27. Rebecca A. Krukowski, **J. Mick Tilford**, Jean Harvey-Berino, Delia Smith West. "Comparing Behavioral Weight Loss Modalities: Incremental Cost-effectiveness of an Internet-based versus an In-person Condition." *Obesity*, 2011 Aug;19(8):1629-35.

28. Nalin Payakachat, **J. Mick Tilford**, Werner Brouwer, Job Van Exel, Scott D. Grosse. "Measuring Health and Well-being effects in Family Caregivers of Children with Craniofacial Malformations. *Quality of Life Research*. 2011 Nov;20(9):1487-95.

29. Dennis Z. Kuo, T. Mac Bird, **J. Mick Tilford**. "Associations of Family-Centered Care with Health Outcomes for Children with Special Health Care Needs." *Maternal and Child Health Journal*, 2011 Aug;15(6):794-805.

30. Scott D. Grosse, Alina L. Flores, Lijing Ouyang, James M. Robbins, **John M. Tilford**. "Impact of Spina Bifida on Parental Caregivers: Findings from a Survey of Arkansas Families." *Journal of Child and Family Studies*, 2009 Oct;18(5): 574-581.

31. Priya Mendiratta, **John M. Tilford**, Parthak Prodhan, Mario A. Cleves, and Jeanne Y. Wei. "Trends in Hospital Discharge Disposition for Elderly Patients with Infective Endocarditis: 1993-2003." *Journal of the American Geriatrics Society*, 2009 May;57(5):877-81.

32. **John M. Tilford,** Scott D. Grosse, Allen C. Goodman, and Kemeng Li. "Labor Market Productivity Costs for Caregivers of Children with Spina Bifida: A Population-Based Analysis." *Medical Decision Making*, 2009; Jan-Feb;29(1):23-32.

33. Bryan L. Burke, James M. Robbins, TM Bird, Charlotte A. Hobbs, Claire Nesmith, **John M. Tilford**. "Trends in Hospitalizations for Neonatal Jaundice and Kernicterus in the United States: 1988 to 2005." *Pediatrics*, 2009; Feb;123(2):524-32.

34. Stephen M. Bowman, Tommy M. Bird, Mary E. Aitken, **John M. Tilford**. "Trends in Hospitalizations Associated with Pediatric Traumatic Brain Injuries." *Pediatrics*, 2008 Nov;122(5):988-93

35. Laura Smith-Olinde, Scott D. Grosse, Frank Olinde, Patti F. Martin, **John M. Tilford**. "Health State Preference Scores for Children with Permanent Childhood Hearing Loss: A Comparative Analysis of the QWB and HUI3." *Quality of Life Research*, 2008 Aug;17(6):943-53.

36. **John M. Tilford.** Allen C. Goodman, Mary E. Aitken, P. David Adelson. "Measuring the Cost-effectiveness of Technologic Change in the Treatment of Pediatric Traumatic Brain Injury." *The Journal of Trauma.* 2007 Dec;63(6 Suppl):S113-20; discussion S121.

37. Mario A. Cleves, Charlotte A. Hobbs, Phillip A. Cleves, **John M. Tilford**, TM Bird, James M. Robbins. "Congenital Defects Among Liveborn Infants with Down Syndrome. *Birth Defects Res.A Clin.Mol.Teratol.* 2007 Aug;79: 657-63.

38. **John M. Tilford.** Mary E. Aitken, Allen C. Goodman, Debra H. Fiser, Jeffrey B. Killingsworth, Jerril W. Green, P. David Adelson. "Child Health Related Quality of Life Following Neurocritical Care for Traumatic Brain Injury: An Analysis of Preference-Weighted Outcomes." *Neurocritical Care*, Neurocrit Care. 2007 Aug;7(1):64-75.

39. James M. Robbins, T.M. Bird, **John M. Tilford**, Mario A. Cleves, Charlotte A. Hobbs, Scott D. Grosse, Adolpho Correa, A. "Hospital Stays, Hospital Charges, and In-Hospital Deaths Among Infants with Selected Birth Defects - United States, 2003." *Journal of American Medicine Association.* 2007 Feb;297(8):802-803

40. T.M. Bird, Charlotte A. Hobbs, Mario A. Cleves, **John M. Tilford**, James M. Robbins. "National Rates of Birth Defects Among Hospitalized Newborns," *Birth Defects Research Part A Clinical and Molecular Teratology.* 2006 Nov;76(11):762-9.

41. James M. Robbins, T.M. Bird, **John M. Tilford**, J. Alex Reading, Mario A. Cleves, Mary E. Aitken, Charlotte M. Druschel, Charlotte A. Hobbs. "Reduction in newborns with discharge coding of *in utero* alcohol effects in the United States, 1993 to 2002," *Archives of Pediatric and Adolescent Medicine. 2006 Dec; 160:1224-1231.*

42. Stephen J. Pont, James M. Robbins, T. M. Bird, James B. Gibson, Mario A. Cleves, **John M. Tilford**, Mary E. Aitken. "Congenital Malformations Among Liveborn Infants with Trisomies 18 and 13." *American Journal of Medical Genetics*, 2006 Aug 15;140(16):1749-56.

43. James M. Robbins, **John M. Tilford**, T. M. Bird, Mario A. Cleves, J. Alex Reading, Charlotte A. Hobbs. "Hospitalizations of newborns with folate-sensitive birth defects before and after fortification of foods with folic acid." *Pediatrics*, 2006 Dec;118(6):2608.

44. Folafoluwa O. Odetola, **John M. Tilford**, Matthew M. Davis. "Variation in the Use of Intracranial Pressure Monitoring and Mortality in Critically Ill Children with Meningitis in the United States." *Pediatrics*, 2006 Jun;117(6):1893-900.

45. Adriana M. Lopez, **John M. Tilford**, K.S. Anand, Chan-Hee Jo, Jerril W. Green, Mary E. Aitken, Debra H. Fiser. "Variation in Pediatric Intensive Care Therapies and Outcomes by Race, Gender, and Insurance Status." *Pediatric Critical Care Medicine*, 2006 Jan;7(1):2-6.

46. Zola K. Moon, Frank L Farmer, **John M. Tilford**. "Attenuation of Racial Differences in Health Services Utilization Patterns for Previously Uninsured Children in the Delta." *The Journal of Rural Health*, 2005 Fall;21(4):288-94.

47. **John M. Tilford,** Mary E. Aitken, KJS Anand, Jerril Green, Allen C. Goodman, James Parker, Jeff Killingsworth, Debra Fiser, and David Adelson. "Hospitalizations for Critically Ill Children with Traumatic Brain Injuries: A Longitudinal Analysis." *Critical Care Medicine*, 2005 Sep;33(9):2074-81.

48. **John M. Tilford**, Scott D. Grosse, James M. Robbins, Jeffrey M. Pyne, Mario A. Cleves, and Charlotte A. Hobbs. "Health State Preference Scores of Children with Spina Bifida and Their Caregivers." *Quality of Life Research*, 2005 May;14(4):1087-98.

49. Jeff Killingsworth, **John M. Tilford**, James Parker, James Graham, Rhonda Dick, Mary E. Aitken. "National Hospitalization Impact of Pediatric All-Terrain Vehicle Injuries." *Pediatrics*, 2005 Mar;115(3):e316-21.

50. Perla A. Vargas, Pippa M. Simpson, J. Gary Wheeler, Rajiv Goel, Charles R. Field, **John M. Tilford**, Stacie M. Jones. "Characteristics of Children with Asthma in a Head Start Program." *Journal of Allergy and Clinical Immunology*, 2004 Sep;114(3), 499-504.

51. Jeffrey R. Kaiser, **John M. Tilford**, Pippa M. Simpson, Walid A. Salhab, Charles R. Rosenfeld. "Hospital Survival of Very Low Birth Weight Neonates from 1977-2000." *Journal of Perinatology*, 2004 Jun;24(6):343-50.

52. **John M. Tilford**, Mario A. Cleves, and Sadia Ghaffar. "Management of Hypoplastic Left Heart Syndrome." (letter) *Pediatrics*, 2003 Nov;112(5):1210-1; and 2004 Feb;113(2):431-2.

53. Zola K. Moon, Frank L Farmer, **John M. Tilford**, and Kelly J. Kelleher. "Dental Disadvantage among the Disadvantaged: Double Jeopardy for Rural Schoolchildren." *Journal of School Health*, 2003 Aug;73(6):242-4.

54. **John M. Tilford** and James G. Parker. A Gender Bias in the Allocation of ICU Resources? *Critical Care Medicine*, 2003 Jul;31(7):2073-4.

55. James M. Robbins, **John M. Tilford**, Stephen R. Gillaspy, Jennifer L. Shaw, Donald D. Simpson, Richard F. Jacobs, J. Gary Wheeler. "Parental Emotional and Time Costs Predict Compliance with Respiratory Syncytial Virus Prophylaxis" *Ambulatory Pediatrics*, 2002 Nov-Dec;2(6):444-8

56. Mary E. Aitken, **John M. Tilford**, Kathleen W. Barrett, James G. Parker, Pippa Simpson, Jeanne Landgraf, James M. Robbins. "Health Status of Children After Admission for Injury." *Pediatrics*, 2002 Aug;110(2 Pt 1):337-42.

57. **John M. Tilford**. "Cost-Effectiveness Analysis and Emergency Medical Services for Children: Issues and Applications." *Ambulatory Pediatrics*, 2002 Jul-Aug;2(4 Suppl):330-6.

58. **John M. Tilford,** James M. Robbins, Charlotte Hobbs. "Improving Estimates of Caregiver Time Cost and Family Impact Associated with Birth Defects." *Teratology*, 2001;64 Suppl 1:S37-41

59. **John M. Tilford,** Pippa M. Simpson, Timothy S. Yeh, Shelly Lensing, Mary E. Aitken, Jerril W. Green, Judith Harr, and Debra H. Fiser. "Variation in Therapy and Outcome for Pediatric Head Trauma Patients." *Critical Care Medicine*, 2001 May;29(5):1056-61.

    Reviewed in *Pediatric Emergency & Critical Care* and *Intensive Care Monitor*.

60. James M. Robbins, **John M. Tilford**, Richard F. Jacobs, J. Gary Wheeler, Stephen Gillaspy, and Gordon E. Schutze. "Costs and Respiratory Syncytial Virus," (letter) *Pediatrics*, 2001 Mar;107(3):608-9.

61. **John M. Tilford**, Pippa M. Simpson, Jerril W. Green, Shelly Lensing, and Debra H. Fiser. "Volume-Outcome Relationships in Pediatric Intensive Care Units," *Pediatrics*, 2000 Aug;106(2 Pt 1):289-94.

    Reviewed in *Research Briefs*.

62. Mingliang Zhang, John C. Fortney, **John M. Tilford**, and Kathryn M. Rost. "An application of the inverse hyperbolic sine transformation," *Health Services and Outcomes Research Methodology*, 2000 Jun;1(2):165-171.

63. Debra H. Fiser, **John M. Tilford**, and Paula K. Roberson. "Relationship of Illness Severity and Length of Stay to Functional Outcomes in the Pediatric Intensive Care Unit: a Multi-institutional Study," *Critical Care Medicine*, 2000 Apr;28(4):1173-9.

64. Allen C. Goodman, **John M. Tilford**, Janet Hankin, Harold D. Holder, and Eleanor Nishiura. "Alcoholism Treatment Offset Effects: An Insurance Perspective," *Medical Care Research and Review*, 2000 Mar;57(1):51-75.

65. KJS Anand and **John M. Tilford**. "Has the Increased Survival of Premature Infants Affected Resource Utilization in Pediatric Intensive Care Units?" *Critical Care Medicine*, 2000 Mar;28(3):900-2.

66. **John M. Tilford**, Paula K. Roberson, Shelly Lensing, and Debra H. Fiser. "Improvement in Pediatric Critical Care Outcomes." *Critical Care Medicine*, (letter) 2000 Feb;28(2):601-3.

67. **John M. Tilford**, James M. Robbins, Sarah J. Shema, and Frank L Farmer. "Response to Health Insurance by Previously Uninsured Rural Children," *Health Services Research*, 1999 Aug;34(3):761-75.

68. Allen C. Goodman, Miron Stano, and **John M. Tilford** (authorship determined alphabetically). "Household Production of Health Investment: Analysis and Applications," *Southern Economic Journal*, 1999 Apr;65(4): 791-806.

69. **John M. Tilford**, Paula K. Roberson, Shelly Lensing, Debra H. Fiser. "Differences in Pediatric ICU Mortality Risk Over Time," *Critical Care Medicine*, 1998 Oct;26(10):1737-43.

Reviewed in *Critical Care Management. Research Briefs*, and abstracted in *Pediatric News*.

70. James M. Robbins, **John M. Tilford**. Richard F. Jacobs, J. Gary Wheeler. Stephen Gillaspy, and Gordon E. Schutze. "A Number Needed to Treat Analysis of the Use of Respiratory Syncytial Virus Immune Globulin to Prevent Hospitalization.." *Archives of Pediatric and Adolescent Medicine*. 1998 Apr;152(4):358-66.

    Reviewed in *Infectious Diseases in Children*.

71. Camilla M. Romund, Frank L Farmer, and **John M. Tilford**. "U.S. Public School Enrollment-based Health Insurance Initiatives and America's Uninsured," *Journal of School Health*. 1997 Dec;67(10):422-7.

72. **John M. Tilford**, William E. Garner, Steven W. Strode. Ann B. Bynum. "Rural Arkansas Physicians and Telemedicine Technology: Attitudes in Communities Receiving Equipment." *The Telemedicine Journal*. 1997 Winter;3(4):257-63.

73. Allen C. Goodman, Eleanor Nishiura, Janet R. Hankin, Harold D. Holder, and **John M. Tilford**. "Long Term Alcoholism Treatment Costs," *Medical Care Research and Review*. 1996 Dec;53(4):441-64..

74. **John M. Tilford** and Debra H. Fiser. "Futile Care in the Pediatric Intensive Care Unit: Ethical and Economic Considerations," editorial. *Journal of Pediatrics*. 1996 Jun;128(6):725-7.

75. Vaughn I. Rickert, Sandra K. Pope, **John M. Tilford**, Sarah Hudson Scholle, John B. Wayne. and Kelly J. Kelleher. "The Effects of Mental Health Factors on Ambulatory Care Visits by Rural Teens," *Journal of Rural Health*. 1996 Summer;12(3):160-8.

B. Book Chapters

1. **J. Mick Tilford** and Ali Raja. "Is More Aggressive Treatment of Pediatric Traumatic Brain Injury Worth It?" in *Economic Evaluation of Child Health*. Wendy Ungar (ed.). Oxford University Press, 2009.

2. Werner Brouwer, Job Van Exel, and **J. Mick Tilford**. "Incorporating Caregiver and Family Effects in Economic Evaluations of Child Health. in *Economic Evaluation of Child Health*. Wendy Ungar (ed.), Oxford University Press, 2009.

C. Non Peer Reviewed Publications

1. Jason Scheel, **J. Mick Tilford**, and Melanie Boyd. HEDIS Measures: Using Numbers to Improve Health in Arkansas. *Journal of the Arkansas Medical Society*. 2010 Feb;106(8):180-1.

2. **J. Mick Tilford**, Child Health Economics at the IHEA 7th World Congress. *iHEAweek* no. 123. September 2009.

3. **John M. Tilford.** Book Review of *The Cost of Birth Defects: Estimates of the Value of Prevention.* by Norman J. Waitzman, Richard M. Scheffler, Patrick S. Romano. *Journal of Perinatology.* 17(2): 175. 1997.

4. Paula K. Roberson, **John M. Tilford**, and Sarah J. Shema. "Developing Instruction in Research Skills for Pediatric Fellows," *Proceedings of the Statistical Education Section of the American Statistical Association*, 1995.

5. **John M. Tilford.** Paula K. Roberson, and Debra H. Fiser. "Using lfit and lroc to Evaluate the Performance of Mortality Prediction Models," *Stata Technical Bulletin.* 28: 14-18. November 1995. Cited in the Stata® User Manual under Logistic Regression.

D. Submitted Manuscripts

1. Scott D. Grosse, Jamison Pike, Rieza Soelaeman, **J. Mick Tilford**. "Quantifying Family Spillover Effects in Economic Evaluations: Measurement and Valuation of Informal Care Time." Submitted to *Pharmacoeconomics.*

2. Clare Brown, **J. Mick Tilford**, D. Keith Williams, Karen A. Kuhlthau, Jeffrey M. Pyne, Werner BF Brouwer, Nalin Payakachat. "Measuring Caregiver Spillover Effects Associated with Autism Spectrum Disorders: A Comparison of the EQ-5D and SF-6D." Submitted to *Pharmacoeconomics.*

3. Sharla Smith, Glen Mays, **J. Mick Tilford**, T. Mac Bird, et al. "Public Health System Partnerships and The Scope of Maternal and Child Services: A Longitudinal Study." Submitted to *Frontiers in Public Health Services and Systems Research.*

E. Professional Reports

1. "Arkansas Health Care Independence Program (Private Option), Section 1115 Demonstration Waiver Interim Report." Prepared for Arkansas Center for Health Improvement, March 2016.

2. **J. Mick Tilford**, Mir Ali, T. Mac Bird, Stephen Bowman, Jake Coffey, Karen Drummond, Holly Felix, Liz Gates, M. Kathryn Stewart, Melanie Boyd, Kristina Bondurant, Anita Joshi, Pedro Ramos, Nichole Sanders, Mayumi. "Arkansas State Partnership Health Insurance Marketplace: Year One Evaluation." Prepared for Arkansas Insurance Department, June 2015.

3. **J. Mick Tilford**, Chenghui Li, and Sharla Smith. "The Economic Cost of Health Inequalities in Arkansas." Prepared for the Arkansas Minority Health Commission, April 2014.

4. **J. Mick Tilford**, Austin Porter, Jason Scheel, Melanie Boyd, and Michelle Pullman. Hospitalizations and Medical Care Costs of Serious Traumatic Brain Injuries, Spinal Cord

Injuries, and Traumatic Amputations. Submitted to Arkansas Spinal Cord Commission. June 2013.

5. **J. Mick Tilford** and William Watson. "Fiscal and Policy Implications for the State of Arkansas from Rebalancing Long Term Care Services and Supports Following Provisions in the Patient Protection and Affordable Care Act of 2010." Arkansas Department of Health and Human Services, Division on Aging. September 2012.

6. Jennifer Sullivan and Kathleen Stoll. "The Great Divide: When Kids Get Sick, Insurance Matters." Families USA, February 2007. Data Analysis and Technical Appendix by **J. Mick Tilford**.

7. "Evaluation of the Family Planning Demonstration Waiver: A Report to the Division of Medical Services of the Arkansas Department of Human Services," October 2004.

8. Kate Stewart, Ann P. Riley, **John M. Tilford.** "Evaluation of the Family Planning Demonstration Waiver: An Interim Report to the Division of Medical Services of the Arkansas Department of Human Services." April, 2002.

9. **John M. Tilford**. "Expansion of Medicaid Services for Children and Pregnant Women in the State of Arkansas: A Cost Analysis," The Governor's Task Force on Health Care Reform, April 1994.

10. **John M. Tilford**. "Access to Medical Care and the Demand for Medical Care." Executive Summary written for the Agency for Health Care Policy and Research. January 1994.

11. **John M. Tilford**. "Cigarette Smoking Behavior and Potential Health Care Savings in the State of Michigan," Final Report to the Michigan Health Care Education and Research Foundation. May 1993.

F. Unpublished Thesis

"Coinsurance, Willingness to Pay for Time, and Elderly Health Care Demand." Unpublished Ph.D. dissertation. Detroit MI: Wayne State University, 1993. Thesis committee: Allen C. Goodman (chair), Gail Jensen, Steve Spurr, Janet Hankins.

G. Lay Publications

1. **J. Mick Tilford.** Health-care Economics and the Federal Mandate. *Arkansas Democrat Gazette*. November 14, 2010.

2. **J. Mick Tilford.** Missing Markets for Health Insurance. *Arkansas Democrat Gazette*. March 29, 2013.

VII. SCIENTIFIC PRESENTATIONS

A. Invited Presentations and Lectures

1. Arkansas Department of Health Grand Rounds, "What Do Students of Health Care Economics Know About Health Care Reform?" March, 2017

2. Arkansas Department of Health Grand Rounds. "The Economic Cost of Health Inequalities in Arkansas," September, 2014

3. Health Disparities Panel for Delta Leadership Institute, "Health Disparities: Economic Cost and Policy Research." September, 2014.

4. International Health Economics Association (IHEA), European Conference on Health Economics (ECHE), "Nursing Roles and Health Care Economics" Dublin, Ireland, July, 2014.

5. Arkansas Minority Health Summit Panel Discussion with Darrell Gaskin, Brian Smedley, and moderated by T.J. Holmes, April 2014.

6. Arkansas Academy of Audiology, Keynote Address, May 2012.

7. NIMH Research Track on Health Care Reform at the American Psychiatric Association Meetings. "Measuring Quality-Adjusted Life Years in Children with Autism." May 2011.

8. Central Michigan University, Department of Economics, "Challenges and Opportunities in the Economic Evaluation of Child Health Services," April 2010.

9. Cincinnati Children's Hospital Grand Rounds. "Challenges and Opportunities in the Economic Evaluation of Child Health," May 2009.

10. Division of Health Services Research, Cincinnati Children's Hospital. "Methods for Addressing Selection Bias in Observational Studies," May 2009.

11. Michigan Department of Health, Lansing, MI. "Incorporating Family Effects in Economic Evaluations of Child Health Interventions." April 2008.

12. National Study on Cost and Outcomes of Trauma (NSCOT) for Kids, sponsored by the Agency for Healthcare Quality and Research, and the Emergency Medical Services for Children program at the Maternal and Child Health Bureau. "Measuring the Cost-effectiveness of Technological Improvement in the Treatment of Traumatic Brain Injury" March 2007.

13. Agency for Healthcare Research and Quality, 10th Healthcare Cost and Utilization Project (HCUP) Partners Meeting. "HCUP Partner Data Contributing to the Public Good: Injury Impact and Policies." March 2006.

14. Centers for Disease Control and Prevention Conference on Prioritizing a Research Agenda for Orofacial Clefts. Atlanta GA. "Caregiver Time Costs." January 2006.

15. Centers for Disease Control and Prevention, Atlanta GA: "Health Effects of Congenital Hearing Loss." March 2005.

16. National Institutes of Arthritis and Musculoskeletal and Skin Diseases Workshop on the Burden of Muscle Disease, Bethesda Maryland, January 2005.

17. Centers for Disease Control and Prevention – Charting the Course: Birth Defects, Developmental Disabilities, and Disability and Health, Atlanta, Georgia: "Health Utilities and Time Costs for Caregivers of Children with Spina Bifida," September 2002.

18. National Congress on Childhood Emergencies, Dallas, TX: "Economic Evaluation," (with Anne Haddix) April 2002.

19. National EMSC Grantee Meeting, Tysons Corner, VA: "Grant Writing." June 2001.

20. Ambulatory Pediatric Association Conference - Improving Emergency Medical Services for Children through Outcomes Research: An Interdisciplinary Approach, Reston Virginia, "Measuring Cost and Cost-effectiveness," March 2001.

21. National Congress on Childhood Emergencies, Baltimore, Maryland: "Cost-Benefit and Cost-Effectiveness Analysis." (with Anne Haddix) March 2000.

22. St. Georges Hospital and Medical School, London, United Kingdom: "Measuring the Cost and Quality of Pediatric Intensive Care Units," June 1999.

23. Aitken Neuroscience Center, New York, NY. "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients." November 1998.

B. Peer-Reviewed Research Presentations (selected)

1. **Tilford JM**, Melanie Boyd, Kristine Bondurant, Holly Felix, Pedro Ramos, Liz Gates, Mir Ali, Stephen Bowman. Comparison of Private Insurance Consumers in Arkansas: Medicaid and Exchange Enrollees. AcademyHealth Annual Research Meeting. June 2016.
2. **Tilford JM.** Ideas for improving health economics content in student term papers. American Society of Health Economist ASHEcon. June 2016.
3. **Tilford JM**, Payakachat N, Kovacs E, Pyne J, Kuhlthau K. Outcomes associated with gastrointestinal disorders for children with autism spectrum disorders and their caregivers. Presented as an organized session with Eve Wittenberg and Lisa Prosser. IHEA/ECHE, July 2014.
4. **Tilford JM**, Payakachat N, Kuhlthau K, Pyne JM, Kovacs E, Brouwer W. Health utilities and caregiver spillover effects associated with sleep problems in children with autism

spectrum disorders. The International Society for Quality of Life Research (ISOQOL) 20th Annual Meeting, Miami, FL, October 2013.

5. Payakachat N, Hoefman RJ, Kovacs, van Exel J, Pyne J, Kuhlthau K, **Tilford JM**, Brouwer W. Quality of life among parents of children with autism spectrum disorders: A comparison of generic instruments. The International Society for Quality of Life Research (ISOQOL) 19th Annual Meeting. Budapest, Hungary, October 24-27, 2012. (Platform)

6. **Tilford JM**, Payakachat N, Pyne JM, Kuhlthau KA, Comparing experienced utility values from generic instruments for caregivers of children with autism. American Society of Health Economists. Minneapolis MN, June 2012.

7. **Tilford JM**, Payakachat N, Pyne JM, Kuhlthau KA, Brouwer WB. Comparing experienced utility values from generic instruments for caregivers of children with autism. European Conference on Health Economics. Zurich Switzerland, July 2012.

8. Payakachat N, **Tilford JM**, Pyne J, Bellando J, Kovacs E, Kuhlthau K. Measuring preference-weighted scores for children with autism spectrum disorders: a comparison of generic instruments. The 8th World Congress on Health Economics: Transforming Health & Economics. Toronto, Canada, July 10-13, 2011 (Platform)

9. **Tilford JM**, Pyne JM, Payakachat N, Bellando BJ, Kuhlthau K. "Measuring quality-adjusted life years for economic evaluations of treatments services for children with autism." 15th NIMH Biennial Research Conference on the Economics of Mental Health: Comparative Effectiveness and Mental Health Care Financing. Washington DC, September 2010.

10. **Tilford JM**, Payakachat N. The CarerQol instrument in relation to measures of health utilities and quality of life outcomes in caregivers of children with craniofacial birth defects. 8th European Conference on Health Economics. Helsinki Finland, 2010.

11. **Tilford JM**, Payakachat N, Grosse SD. Comparison of health utility and quality of life measures in family caregivers of children with craniofacial birth defects and autism. American Society of Health Economists, Ithaca NY, 2010.

12. Payakachat N, Grosse SD, **Tilford JM**. Comparison of health utility and quality of life measures in family caregivers of children with craniofacial birth defects. Presented at International Society of Quality of Life meeting in New Orleans, LA, 2009.

13. **Tilford JM**, Raja AI. Is more aggressive treatment of pediatric traumatic brain injury worth it? Presented at International Health Economics Meetings in Beijing China, July 2009.

14. Goodman AC, **Tilford JM**. Sleep Matters! Insights from caregivers of children with disabilities. Presented at the meeting of the American Society of Health Economists, Durham NC, 2008.

15. **Tilford JM**, Fussell J, Schulz E, Casey PH. Family impacts of autism: Analyses from the 2005-2006 national survey of children with special health care needs. Society for Pediatric Research, Waikiki HA, 2008.

16. **Tilford JM**. Correlates of caregiver preference scores. Presented at International Health Economics Meetings in Copenhagen Denmark, July 2007.

17. Bird TM, Hobbs CA, Cleves MA, **Tilford JM**, Aitken ME, Robbins JM. Newborn hospitalizations of infants with congenital diaphragmatic hernia in the US, 1993-2003. Presented at Society for Pediatric Research meetings, Toronto, CA, May 2007.

18. Mendiratta P, **Tilford JM**, Wei J. National trends in percutaneous endoscopic gastrostomy tube placement among hospitalized elderly patients in the United States, American Geriatric Society Annual Meeting, Seattle WA, May 2007.

19. Bird TM, Hobbs CA, Cleves MA, **Tilford JM**, Aitken ME, Robbins JM. Newborn hospitalizations of infants with congenital diaphragmatic hernia in the US, 1993-2003. Presented at National Birth Defects Prevention Network meetings, San Antonio, TX, January 2007.

20. Grosse SD, Smith-Olinde L, **Tilford JM**. Valuing the Health of Children with Congenital Hearing Loss: New Findings from the Arkansas Children's Hospital. DHDD Seminar, October 13, 2006.

21. Powerful Data, Meaningful Answers -- The HCUP Kids' Inpatient Database (KID) and the Nationwide Inpatient Sample (NIS). Session panel (with Anne Elixhauser and Pamela Owens from AHRQ) at the Child Health Services Research Interest Group Meeting of AcademyHealth, Seattle Washington, June 2006

22. **Tilford JM**. Goodman AC, Adelson PD. Is More Aggressive Treatment of Pediatric Traumatic Brain Injury Worth It? American Society of Health Economists, Madison Wisconsin, June 2006.

23. Mendiratta P, **Tilford JM**, Wei J. Trends In Hospital Discharge Disposition For Elderly Patients With Infective Endocarditis. American Geriatric Society Annual Meeting, Chicago IL, May 2006.

24. Cleves MA, Hobbs CA, Cleves PA, **Tilford JM**, Bird TM, Robbins JM. Major birth defects among live born infants with Down syndrome in the United States: 1993 through 2002. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

25. Bird TM, **Tilford JM**, Cleves MA, Hobbs CA, Robbins JM. National birth defect surveillance rates: Administrative data from the Healthcare Cost and Utilization Project compared to select state surveillance systems. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

26. Robbins JM, Bird TM, **Tilford JM**, Cleves MA, Hobbs CA. Length of newborn hospital stay, hospital charges and in-hospital deaths among infants with major birth defects in the United States. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

27. **Tilford JM**, Grosse SD, Robbins JM, Hobbs CA. How does spina bifida affect parental caregivers? Findings for a survey of families in Arkansas. Presented at National Birth Defects Prevention Network meetings, Arlington, VA, January 2006.

28. Robbins JM, Bird TM, **Tilford JM**, Reading AJ, Cleves MA, Aitken ME, Druschel CM, Hobbs CA. Reduction in newborns diagnosed with fetal alcohol exposure in the Unites States, 1993 to 2002. Presented at National Birth Defects Prevention Network meetings. Arlington, VA, January 2006.

29. Smith-Olinde L, **Tilford JM**, Grosse S, Martin PF, Olinde FL. Comparing preference scores of children with congenital hearing loss. *The Bulletin of the American Auditory Society*, 30, 46. 2005.

30. Smith-Olinde L, **Tilford JM**, Grosse SD, Martin PF, Olinde FL. Comparing preference scores of children with congenital hearing loss. Research Poster, *Annual Meeting, American Auditory Society*, Scottsdale, AZ, 2005.

31. **Tilford JM**, Grosse SD, Martin P, Smith-Olinde L. "Health State Preference Scores of Children with Congenital Hearing Loss and Their Caregivers," International Health Economics Association, Barcelona, Spain, July 2005.

32. Robbins JM, Bird TM, **Tilford JM**, Hobbs CA. Can hospital discharge data complement birth defects surveillance? Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

33. Robbins JM, Bird TM, **Tilford JM**, Reading JA, Cleves MA, Aitken MA, Hobbs CA. Reductions in newborns diagnosed with fetal alcohol syndrome in the United States 1993 to 2002. Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

34. Bannister T, **Tilford JM**. Does Teaching Status Influence Medical Errors and Mortality in Pediatric Injury Hospitalizations? Presented at Academy Health, Child Health Services Research meeting, Boston, June 2005.

35. Bird TM, **Tilford JM**, Cleves MA, Hobbs CA, Robbins JM. Surveying birth defects in states with limited surveillance systems: The value of administrative data. Presented at Southern Society for Pediatric Research meetings, New Orleans, February 2005.

36. Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW, Hobbs CA. "Hospitalizations of Infants with Birth Defects in the United States Before and After Fortification of Grains with Folic Acid." National Congress on Birth Defects and Developmental Disabilities (CDC), Washington DC, July 2004.

37. Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW, Hobbs CA. Newborn hospitalizations for birth defects in the pre and post folic acid fortification periods. Presented at Academy Health meetings, San Diego, June 2004.

Selected as most outstanding paper in child health

38. **Tilford JM**, Aitken ME, Goodman AC, Green JW, Killingsworth JB, Fiser DH. "Pediatric Hospitalizations for Traumatic Brain Injuries: 1997 and 2000." AcademyHealth, San Diego, CA, June 2004.

39. Odetola FO, **Tilford JM**, Davis MM: Utilization of Intracranial Pressure Monitors in Critically Ill Children with Meningitis. AcademyHealth Annual Meeting, June 2004.

40. Odetola FO, **Tilford JM**, Davis MM: Utilization of Intracranial Pressure Monitors in Critically Ill Children with Meningitis. Pediatric Academic Societies' Annual Meeting, May 2004.

41. Hobbs CA, Robbins JM, **Tilford JM**, Bird TM, Cleves MA, Reading JA, Thompson JW. Have newborn hospitalizations for birth defects declined following fortification of foods with folic acid? Presented at Society for Pediatric Research meetings, San Francisco, May 2004.

42. Thompson JW, **Tilford JM**, Elixhauser AE. "Using the Kid's Inpatient Database," Society for Pediatric Research, Seattle WA, May 2003.

43. Green JW, Robbins JM, Shaw JL, Simpson DD, **Tilford JM**. The effect of hospitalization on the families of otherwise healthy infants with bronchiolitis. Presented at Society for Pediatric Research meetings, Seattle, May 2003.

44. **Tilford JM**, Killingsworth JB, Green JW, Aitken ME. Analysis of pediatric traumatic brain injury over time: Incidence, therapies, and outcome. Southern Society for Pediatric Research, New Orleans, LA, February 22, 2003. *Journal of Investigative Medicine* 2003; 51: Supplement 1; S307.

45. **Tilford JM**. "Children with Spina Bifida: Health Utilities and Caregiver Time Cost." APHA130th Annual Meeting & Exposition, Philadelphia, PA, November 2002.

46. **Tilford JM,** Robbins JM, Grosse SD. "Health Utility Relationships for Caregivers of Children with Spina Bifida." International Society for Quality of Life Research, Orlando FL, November 2002.

47. Killingsworth JB, **Tilford JM.** "Are Outcomes Improving for Pediatric Patients with Severe Traumatic Brain Injury?" National Congress on Childhood Emergencies, Dallas TX, April 2002.

48. **Tilford JM**, Farmer FL, Kelleher KJ, Robbins JM. "Fluoridation and Children's Demand for Dental Care: Analysis of Two Rural Communities." International Health Economics Association, York UK, July 2001.

49. **Tilford JM**. "Willingness to Pay for a Reduction in Doctor's Office Waiting Time." International Health Economics Association, York UK, July 2001.

50. **Tilford JM**, Farmer FL, Kelleher KJ, Robbins JM. "Fluoridation and Children's Demand for Dental Care: Analysis of Two Rural Communities." Society for Pediatric Research, May 2001.

51. **Tilford JM**, Aitken ME, Simpson PM, Lensing S, Green JW, Fiser DH. "Variation in Pediatric Intensive Care Unit Therapies by Race and Insurance Status," Association for Health Services Research, June 2000.

    Finalist for Best Paper

52. **Tilford JM**, Zhang M. "Modeling Health Care Demand with the Inverse Hyperbolic Sine Transformation," International Health Economics Association Meetings, Rotterdam, The Netherlands, June 1999.

53. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients," Association for Health Services Research, June 1999.

54. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Volume-Outcome Relationships in Pediatric Intensive Care Units," Society for Pediatric Research, May 1999.

55. Robbins JM, **Tilford JM**, Gillaspy SR, Thomas MD, Lensing SY, Wheeler JG. "Emotional and time costs of RSV-IG." Society for Pediatric Research meetings, May, 1999.

56. **Tilford JM,** Simpson PM, Lensing S, Fiser DH. "Volume-Outcome Relationships in Pediatric Intensive Care Units," Southern Society for Pediatric Research, February 1999.

57. Robbins JM, **Tilford JM**, Gillaspy SR, Thomas MD, Lensing SY, Wheeler JG. "Baby and parental reactions to RSV-IG administration." Southern Society for Pediatric Research meetings, February, 1999.

58. **Tilford JM**, Simpson PM, Lensing S, Harr J, Fiser DH. "Comparison of Resource Utilization and Readmissions in Pediatric Intensive Care: The Impact of a Monitored Care Unit." Association for Health Services Research, June 1998.

59. **Tilford JM**, Simpson PM, Lensing S, Fiser DH. "Differences in Pediatric ICU Risk of Mortality Over Time." Southern Society for Pediatric Research, February 1998.

60. Watson JE, **Tilford JM**, Fiser DH, Casey PH. "Failure-to-Thrive as a Comorbidity in the Pediatric Intensive Care Unit: Prevalence and Resource Use." Southern Society for Pediatric Research Annual Meetings, February 1998.

61. Robbins JM, Wheeler JG, Gillaspy SR, **Tilford JM**, Cheadle MG, Clayton JE. Follow-up of infants treated with respiratory syncytial virus immune globulin. Southern Society for Pediatric Research, February 1998.

62. **Tilford JM**. "Quality and Cost-Containment in Pediatric Intensive Care," Emergency Medical Services for Children National Meeting, January 1997.

63. **Tilford JM**, Robbins JM, Farmer FL. "Utilization and Costs of Vision Benefits by Previously Uninsured School-Aged Children." Southern Society for Pediatric Research, February 1997 meetings.

64. **Tilford JM**, Robbins JM, Marshall JM, Flick EM, Mohrmann H. "Relationship Between Prescribed Medicines, Emergency Department Use, and Inpatient Hospitalizations for Children with Asthma." Southern Society for Pediatric Research, February 1996 meetings.

65. Robbins JM, **Tilford JM**, Sissel PA, Manjanatha S, Farmer FL. "Predictors of Health Care Utilization Among Children in the Mississippi Delta." Southern Society for Pediatric Research Annual Meetings, February 1996.

66. Kellogg KW, Fawcett DF, Scholle SH, Anders M, **Tilford JM**, Robbins JM. "Costs of Delivering Beta-Agonist in a Protocol Driven Respiratory Care Plan for Asthma." Southern Society for Pediatric Research Annual Meetings, February 1996.

67. **Tilford JM**, Roberson PK, Lensing S, Fiser DH. "Cost Containment and Clinical Performance in Pediatric Intensive Care," Association for Health Services Research, Chicago, June 1995 meetings.

68. **Tilford JM**, Robbins JM, Shema SJ, Field C, Farmer FL, Kelleher KJ, Association for Health Services Research, Chicago, June 1995 meetings "Health Care Utilization and Costs of Previously Uninsured Rural Children."

69. Roberson PK, Shema SJ, **Tilford JM**. "Developing Instruction in Research Skills for Pediatric Fellows." American Statistical Association Annual Meeting, August 1995.

70. Rickert VI, Pope SK, **Tilford JM**, Scholle SH, Wayne J, Kelleher KJ. "The Effects of Depression and Problem Drinking on Rural Adolescent Ambulatory Health Care Use." Society for Adolescent Medicine, March 1995.

71. Shema SJ, Robbins JM, **Tilford JM**, Farmer FL, and Kelleher KJ. "Health Status of Uninsured Rural Adolescents." Southern Society for Pediatric Research Annual Meeting, 1995.

72. **Tilford JM**, Robbins JM, Shema SJ, Feild C, Farmer FL, and Kelleher KJ. "Insuring The Uninsured: Health Care Expenditures By Rural Children." Southern Society for Pediatric Research Annual Meetings, 1995.

73. **Tilford JM**. "Coinsurance, Time, and Differential Use of Health Care Among the Medicare Elderly." Association for Health Services Research, San Diego, June 1994 meetings.

74. Fiser DH, Roberson PK, **Tilford JM**, Harshbarger S, and the Pediatric Critical Care Study Group. "Prediction of Functional Outcome in PICU: A Multi-Institutional Study." Society of Critical Care Medicine, Annual Meetings, 1994.

75. **Tilford JM**. "Coinsurance, Willingness to Pay for Time, and Elderly Health Care Demand." American Public Health Association - Health Economics Committee, Washington D.C., October 31, 1994.

76. Fiser DH, Roberson PK, **Tilford JM**, Robbins JM, Pope SK, Kirby RS, Shema SJ. "Severity and Case-Mix Adjusted Outcome: A Measure of One Dimension of Quality in Pediatric Intensive Care? Society for Pediatric Research, 1994.

VIII. TEACHING AND EDUCATIONAL ACTIVITIES

A. Courses Taught

HSRE 9723: Advanced Health Economics II: Supply-side Economics (Role: Sole Instructor). Three credit hours. This doctoral-level course provides an advanced examination of the supply side of health economics, including theory, methods, and policy implications. The course covers theory and methods for modeling the supply of health care, the theory of managed care insurance and various frameworks for understanding the allocation of resources to hospitals and other providers in the health care system. A key goal of this course is for students to obtain a firm understanding of how researchers attempt to model provider behavior and systems of care. UAMS College of Public Health, Fall 2017 (4 students), Fall 2013 (2 students), Fall 2010 (4 students).

HSRE 9723: Advanced Health Economics I: Demand-side Economics (Role: Sole Instructor). Three credit hours. This doctoral-level course provides an advanced examination of the demand side of health economics, including theory, methods, and policy implications. The course covers theory and methods for modeling the demand for health and health care, the theory of health insurance and various frameworks for incorporating health insurance coverage into models of health care demand, and empirical studies that explicitly account for health, health care, and health insurance in determining labor supply. A key goal of this course is for students to obtain a firm understanding of how researchers attempt to capture the economic aspects of consumer health behavior when studying the impact of health policies and systems of care. UAMS College of Public Health.), Fall 2016 (4 students), Fall 2012 (1 student), Fall 2011 (1 student).), Fall 2009 (2 students).

HSRE 9203: Variation in Health System Performance (Role: Primary Instructor). Three credit hours. At its core, the field of health services research is devoted to the study of variation in health system performance and health care practice. As the second semester in the two-semester sequence, this doctoral-level seminar will focus on what can be learned from studies of variation in health systems and services – investigating the causes, consequences, and solutions to harmful, wasteful, and inequitable variation. In doing so, this course will review conceptual foundations of health services and systems research (HSR), and examine current topics and ongoing research in this field. Students will examine current empirical research conducted by investigators concerning the development, organization, financing, and delivery of health services and their impact on population health. Students will also gain experience in conceptualizing research questions of interest in HSR, developing theoretical frameworks to inform these questions, and critically reviewing the

empirical literature on topics of interest. UAMS College of Public Health, Spring 2017 (4 students), Spring 2016 (4 students), Spring 2015 (4 students), Spring 2013 (2 students).

HSAD 5273: Introduction to Health Economics (Role: Sole Instructor). Three credit hours. Economics is the study of the allocation of scarce resources. Health economics considers the allocation of health care resources to evaluate whether more efficient or equitable distributions can be achieved. The course is a survey of economic issues on significant topics in the health care field. Some topics could stand as a single course. The first class sessions reintroduce economics principles; the subsequent sessions expand on these principles and apply them to health care. UAMS College of Public Health, Spring 2017 (21 students), Spring 2016 (28 students), Spring 2015 (32 students), Spring 2014 (29 students), Spring 2013 (21 students), Spring 2012 (11 students), Fall 2011 (directed study with 3 students), Spring 2011 (20 students), Spring 2010 (19 students), Summer 2008 (2 students), Spring 2007 (16 students), UALR Spring 2003 (14 students), UALR Spring 2002 (16 students), UAMS Division of Biometry Spring 2001 (7 students), UAMS Division of Biometry Spring 1999 (4 students).

Research Skills Course: Developing Grant and Journal Submissions. (Role: Course Director in 1996 and 1997; Course Coordinator in 1994). Non-credit course. This course provided instruction in research designs, introductory statistics, and research skills necessary for preparing research projects from abstract submissions to grant applications. Intended audiences were fellows and junior faculty in the Department of Pediatrics. Fall 1997 (14 students; 23 CME credit hours), Fall 1996 (11 students; 20 CME credit hours). Fall 1994 (15 students; 36 CME credit hours).

Principles of Economics. (Role: Course Director). Three credit hours. This course provides an introduction to principles of micro or macroeconomics. The course is intended for freshman college students and provides a basic understanding of supply and demand for goods and services, market structures, and the role of prices. Wayne State University (1987-1991 with approximately 30 students), Central Michigan University (1984-1985 with approximately 35 students), University of Minnesota – Duluth (1985-1986 with approximately 200 students).

Introductory Statistics. (Role: Course Director). Three credit hours. This course provides business students with an introduction to statistics including basic descriptive statistics, hypothesis testing, and linear regression. University of Minnesota – Duluth (1985-1986 with approximately 20 students), Jackson Community College (1982-1983 with approximately 15 students).

B. Teaching Lectures in University Setting

1. College of Nursing UAMS. Leadership in Healthcare Systems Class "Finance and Health Economics" September 19, 2014. November 6, 2015. July 21, 2016.

2. Cancer Institute Grand Rounds. UAMS. "The revolution in comparative effectiveness research." With Brad Martin, February 27, 2013.

3. College of Public Health UAMS, "Measuring quality-adjusted life years in children with autism." January 11, 2013.

4. College of Public Health UAMS, "The revolution in comparative effectiveness and patient-centered outcomes research: A framework for assessing interventions for children with autism." March 6, 2012.

5. Division of Health Services Research, Department of Psychiatry UAMS. "Measuring quality-adjusted life years in children with autism." December 6, 2010. (With N. Payakachat).

6. College of Public Health UAMS. "Can cost-effectiveness analysis inform financing decisions associated with treatment for autism?" November 2, 2010. (With N. Payakachat)

7. Leadership Education in Neurodevelopmental and Related Disabilities, "Economic Evaluation of Child Health Services for Children with Neurodevelopmental Disabilities." UAMS, April 23, 2010.

8. Health Policy and Promotion Conference, College of Public Health. "Challenges in the Economic Evaluation of Child Health Services," January 16, 2008

9. Health Policy and Promotion Conference, College of Public Health (with P. Mendiratta). "Trends in Hospital Discharge Decisions for Elderly Patients Hospitalized with Infective Endocarditis." January 30, 2007.

10. Health Policy and Promotion Conference, College of Public Health. "Is More Aggressive Treatment of Traumatic Brain Injury in Children Worth It?" July 25, 2006.

11. Jones Eye Institute Grand Rounds, "Introduction to Health Economics," April 13, 2006.

12. Pediatric Faculty Development Seminar. "Using Reference Manager for Your Publications." February 21, 2006.

13. College of Medicine Dean's Research Forum, "Measuring the Return on Investment from Medical Research." October 25, 2005.

14. Pediatric Critical Care Medicine Seminar, "Impact of ICP Monitoring on Outcome in Critically Ill Children with Meningitis: An Application of the Propensity Score Method to Reduce Bias in Observational Studies." October 7, 2005.

15. College of Medicine, UAMS, Introduction to Clinical Medicine I Course, *Health Care Finance*, August 31, 2005.

16. College of Nursing Research Seminar, "Health State Preference Scores of Children with Spina Bifida and Their Caregivers." April 6, 2004.

17. Arkansas Center for Health Improvement: Health Policy Forum, "Developing the Basis for Universal Health Insurance for Children." June 4, 2002.

18. Department of Pediatrics Grand Rounds, "Universal Health Insurance for Children," January 22, 2002.

19. Center for Outcomes Research and Effectiveness, UAMS, "Variation in the Use of Intracranial Pressure Monitoring for Pediatric Head Trauma Patients," September 22, 1999.

20. College of Nursing - Nurse Theory Course, UAMS, "Introduction to Health Economics," March 19, 1999.

21. Arkansas Children's Hospital - Nursing Grand Rounds, "Hospital Cost and Quality," March 9, 1999.

22. Center for Outcomes Research and Effectiveness, UAMS, "Risk Adjustment Systems in Pediatrics: Methods and Applications." May 27, 1998.

23. Statistical Journal Club, UAMS, "A Note on Alternative Models of the Demand for Health Care," March 10, 1998.

24. Department of Pediatrics Evidence-Based Medicine Lecture Series, "Economic Evaluation of Health Services," December 4, 1997.

25. UALR Master's Program in Health Administration, "Health Care Reform," April 29, 1997.

26. Center for Outcomes Research and Effectiveness (CORE) Scholar Lecture, "Severity Adjustment," January 30, 1997

27. Seventh Annual Professional Development Day – UAMS, "A Primer on Illness Severity, Health Care Costs, and Quality of Care," Little Rock, October 21, 1997.

28. Department of Pediatrics Research Conference, "A Primer on Illness Severity, Resource Use, and Quality of Care," December 5, 1996.

29. Center for Outcomes Research and Effectiveness, UAMS, "Cost Containment and Clinical Performance in Pediatric Intensive Care," March 8, 1995.

30. UALR Master's Program in Health Administration, "Health Services Research," April 5, 1995.

31. Department of Pediatrics Grand Rounds, "Hospital Care: Time to Consider both Cost and Quality," November 8, 1994.

C. Teaching Lectures in a Community Setting

1. Arkansas Primary Care Association Annual Meeting, "Healthcare Economics and the Accountable Care Act," September 2016.

2. Adventures in Learning, "It's the Economy Stupid," Little Rock, April 6th – May 25th, 2005.

3. St. Vincent Health System, Focus Group Participant for Community, November 2004.

4. Case Management Society of America, "A Primer on Cost and Outcomes Measurement," Little Rock, September 1997.

5. Americorps National Service Orientation, "Problems and Prospects for Rural Health Care Services," Little Rock, May 22, 1995.

6. Arkansas School for Mathematics and Science, Panel Discussant, Little Rock, March 16, 1995.

D. Clinical Scientist Mentoring

2006 – 2008: Bryan Burke, M.D.
2006 – 2008: Laura Smith-Olinde, Ph.D.
2004 – 2005: Fola Odetola, M.D.
1998 – 2004: Jeff Kaiser, M.D.
1996 – 1997: Al Torres, M.D.

E. Fellow Advising

2011 – 2013: Barbara Saunders, M.D.
2006 – 2008: Priya Mendiratta, M.D.
2004 – 2007: Tom Bannister, M.D.
2003 – 2004: Adrianna Lopez, M.D.

F. Dissertation Committee

2018 – Adrienne Nevola (Chair)
2017 – Clare Brown (Chair)
2015 – Mir Ali (Chair)
2015 – 2018: Leah Richardson
2015 – 2017: Rebecca Pope (Chair)
2014 – 2017: Marcia Byers
2014 – 2015: Teresa Hudson
2013 – 2016: Patty Smith
2012 – 2013: Michael Preston (Chair)
2012 – 2013: Sharla Smith (Chair)

2011 – 2013: Diane Robinson (Chair)
2009 – 2011: Mac Bird
2005 – 2007: Angela Green, RN

G. MS/MPH Advising

2018 – Dimple Shah
2017 – Josh Salil
2017 – 2018 Jennifer Morales
2017 – 2018 Jennifer Victory
2016 – 2017 Savannah Skaggs
2016 – 2017 Kristen Alexander
2015 – 2016 John Ukadike
2014 – 2015 Clare Brown
2014 – 2015 Alexandria Beebe
2014 – 2015 Aaron Carroll
2012 – 2013 Pratik Doshi
2012 – 2013 Sabha Talibi
2012 – 2013 Julia Kettlewell
2012 – 2013 Cody Haedon
2010 – 2011 April Moore, MPH
2002 – 2004 Jeff Killingsworth, MPH

H. Mentoring Committee (Chair)

2006 – 2009: Nahed El-Hassan, M.D., MPH

I. Summer Science Student Mentoring

2006: Tammy E. Binz
2017: James Abraham

J. Junior Faculty Mentoring

2015 – Taren Swindle
2013 – Sharla Smith, PhD
2012 – Anthony Goudie, PhD (KL2 Scholar Primary Mentor)
2009 – Qayyim Said, PhD
2009 – Nalin Payakachat, PhD

IX. SERVICE ACTIVITIES

A. University Service Activities

Intercollegiate Faculty Council, University of Arkansas Medical Sciences Faculty Center, 2016-2017.

Panel member. University of Arkansas Medical Sciences. Office of Grants & Scientific Publications. presentation on experiences and responding to questions about the NIH peer-review process. "Fund My Grant! Learn How to Make It Happen from a Panel of Expert Reviewers." April. 2015.

Legislative Testimony. Arkansas State Public Health and Welfare Legislative Committee. Testified on a report commissioned by the Arkansas Minority Health Commission. The Economic Cost of Health Inequalities in Arkansas, September. 2014.

Dean's Executive Committee, Fay W. Boozman College of Public Health. University of Arkansas for Medical Sciences, 2013 – present. The DEC is the governing body of the COPH.

Graduate Council. University of Arkansas for Medical Sciences (2012 – 2014). The Graduate Council is the governing body of the UAMS Graduate School.

Arkansas Consortium for Health Services Research Executive Committee. University of Arkansas for Medical Sciences (2006-2008). The executive committee provides advice on data infrastructure for conducting health services research.

PhD Admissions Committee for Health Systems Research, College of Public Health. University of Arkansas for Medical Sciences (2006 - 2013). The committee votes on accepting prospective students to the Ph.D. program.

Human Research Advisory Committee. University of Arkansas for Medical Sciences (2000 – 2004). Served as a reviewer and participated in the development of standard operating procedures.

Strategic Plan Committee for Pediatric Administration, Department of Pediatrics. University of Arkansas for Medical Sciences (2000 – 2001). Assisted with the creation of white papers for planning administrative services.

Research Council. Arkansas Children's Hospital Research Institute (1998 1999). Research investigators reviewed policies and procedures associated with the Research Institute.

Governor's Health Care Reform Task Force. State of Arkansas (1993 – 1994). Developed a cost analysis for expansion of health insurance to children.

College of Medicine. UAMS. Admissions Interviews, 2007, 2003, 2001, 2000, 1999 (2). Interviewed prospective medical students and filed a report.

B. Professional Service Activities

Ad Hoc Grant Reviewer for **National Institute of Mental Health**. July 2017.

Advisory Board Participant, **Roche Ltd**, October 2016.

Ad Hoc Grant Reviewer for **Netherland Organisation for Scientific Research**. December 2012.

Ad Hoc Grant Reviewer for **Military Operational Medical Research Program (RAD 3),** June 2012.

Symposium Organizer on Economics of Child Health for **International Health Economics Association.** Toronto Canada. July 2011.

Ad Hoc Grant Reviewer for **Agency for Healthcare Research and Quality – Research Centers for Excellence in Clinical Preventive Services,** July. 2011.

Ad Hoc Grant Reviewer for **National Institutes of Health – Healthcare Delivery and Methodologies (HDM) IRG,** October, 2010.

Ad Hoc Grant Reviewer for **National Institutes of Mental Health – Mental Health Services in Specialty Settings (SRSP)** review committee at NIMH, October, 2010.

Invited Participant for NIMH workshop on Informatics for Autism Research: Community-Wide Solutions. August, 2010.

Ad Hoc Grant Reviewer for **Maternal and Child Health Bureau – Health Resources and Services Administration**. 2005, 2004, 2002, 2001 (2), 1999 (2), 1998, 1997.

Ad Hoc Grant Reviewer and Panel Chair for **Maternal and Child Health Bureau – Health Resources and Services Administration**, June 2002.

Member of Poster Award Committee for conference of the **International Health Economics Association**. Beijing China. 2009.

Member of Scientific Committee for conference of the **International Health Economics Association**. 2009. 2011.

Member of Scientific Committee for conference of the **American Society of Health Economists**. 2008

Member of Scientific Committee for inaugural conference of the **American Society of Health Economists**. 2006

Member of Project Steering Committee. **American Academy of Pediatrics**. Evaluation of care of children in the emergency department: Guidelines for preparedness.

Member of Advisory Council for Emergency Medical Services for Children program. **Maternal and Child Health Bureau, Health Resources and Services Administration**. National trauma registry for children project.

Member of Planning Committee for interdisciplinary conference on Emergency Medical Services for Children. **Ambulatory Pediatric Association**. 2000 - 2001

Member of the Research, Evaluation, and Information Systems task force to revise 5-year plans for the **Emergency Medical Services for Children program, Maternal and Child Health Bureau**, June 1999 – 2001

C. Community and Public Service Activities

Member of the Rehabilitation Subcommittee for the **Arkansas Trauma Advisory Council**, 2012.

Member of cost analysis group for Arkansas' Closing the Addiction Treatment Gap project, **Division of Behavioral Health Services, Arkansas Department of Human Services**, 2009.

Senior Analyst for the **Arkansas Foundation for Medical Care** to assist with data mining and program evaluation.

Technical Consultant for Epidemiology Division of the **Arkansas Department of Health** to assist with return on investment calculations associated with reductions in hospitalizations of tobacco related conditions.

Technical Consultant to **Michigan Department of Community Health**, Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology to assist with economic evaluation of caregiver interventions.

D. Services to Academic/Professional Journals and Editorial Boards

Editor: Health Economics Network (HEN) journal: *Economic Evaluation Methods*

Journal Reviewer:

Ambulatory Pediatrics
Applied Health Economics and Health Policy
BMC Health Services Research
Clinical Performance and Quality Health Care
Contemporary Policy
Critical Care Medicine
Frontiers in Public Health Systems and Services Research
Health Affairs
Health and Quality of Life Outcomes
International Journal for Quality in Health Care
JAMA Pediatrics
Journal of Autism and Developmental Disabilities
Journal of General Internal Medicine
Journal of Health Care for the Poor and Underserved
Journal of Pediatrics
Journal of Rural Health
Journal of the Canadian Academy of Child and Adolescent Psychiatry

Medical Care
Medical Decision Making
NEJM
Neurology and Therapy
Obesity
Pediatrics
Pharmacoeconomics
Social Science and Medicine
The Patient
Quality of Life Research
Value in Health

Book Reviewer:

The Economics of Health and Health Care. Sherman Folland. Allen Goodman. and Miron Stano. Prentice-Hall Inc.: Upper Saddle River, NJ, 1997.

Monograph Reviewer:

Congressional Office of Technology Assessment, *Non-Financial Barriers to Access to Health Care*. 1993.

Discussant:

American Public Health Association. Session on Prevention and Long Term Care. November 1997

International Health Economics Association. Session on Teaching. July 2011.

E. Professional Memberships

American Society of Health Economists

International Health Economics Association

AcademyHealth

American Economic Association

International Society for Quality of Life Research

X. AWARDS AND HONORS

2018 Recipient of the Outstanding Faculty Award from the College of Public Health Student Council.

2006 Recipient of Best Project Award from Emergency Medical Services for Children Program for Economic Evaluation of Intensive Care Services for Pediatric Traumatic Brain Injury Patients.

2000 Educator of the Year Award from the Department of Pediatrics, University of Arkansas for Medical Sciences.

1998 Excellence in Medical Education Award from the Department of Pediatrics. University of Arkansas for Medical Sciences.

1997 Excellence in Research Award from Blue Cross Blue Shield of Michigan Foundation for a research paper entitled "Long Term Alcoholism Treatment Costs" co-authored with Allen Goodman and others.

1993 Dissertation Research Award from the Agency for Health Care Policy and Research of the Department of Health and Human Services (DHHS).

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES AND PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Supplementary Affidavit of Nathan Johnson

My name is Nathan Johnson. I submit this supplementary affidavit in support of the captioned matter to provide current information as to the loss of revenue experienced by PPAEO Fayetteville and Little Rock health centers as a result of ADH's current interpretation of § 20-16-1703(d). PPAEO experienced a loss of $2,957.00 between March 23, 2018 and July 10, 2018 from patients who were billed for services provided at their first visit and who did not remit payment. (I have included in my calculations only those patients who received services on or before July 10, 2018 as these patients were sent bills over 30 days ago). The $2,957.00 represents a combined loss of patient revenue from both health centers for these patients. Pursuant to ADH's interpretation of the requirement being challenged in this matter, PPAEO staff collected no payments for services obtained during those patients' first visits.

FURTHER AFFIANT SAYETH NOT

State of Kansas)
County of Johnson)

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 8/17/2022 (Seal or Stamp)

Leanne Mayer
Notary Public

LEANNE MAYER
My Appointment Expires
August 17, 2022

Bettina E. Brownstein Law Firm
904 W. Second St, Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com
October 11, 2018

Ann Purvis, Esq.
Deputy Director for Administration
Arkansas Dept. of Health
4815 W. Markham St.
Little Rock, AR 72205

Re: In the Matter of Arkansas Dept. of Health v. Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains

Dear Ann:

As attorney for Respondents, pursuant to A.C. A. §25-15-213(C), I submit this affidavit of disqualification as to the following members of the Board of Health and ask that they not be permitted to participate in the adjudication of the referenced matter:

Nathanial Smith, M.D.
Susan Weinstein, D.V.M
Thomas Jones, Sanitarian
Mark Riddell, M.D.
Terry Yamauchi, M.D.
Eddie Bryant, M.D.

My basis for asserting that Dr. Smith should be disqualified is that there is a conflict of interest between his participation in what is purportedly an impartial adjudication by the Board of Health of the deficiency citations that are the subject of this appeal and his position as Director of the agency which investigated and issued the citations. My basis for asserting that Dr. Riddell and Mr. Jones be disqualified is similar: as employees of the agency which investigated and issued the citations, they also have a conflict of interest in adjudicating the appeal. In addition, as employees under the authority of Dr. Smith, it is at least likely that it would be difficult for them to take a position on the validity of the citations that is adverse to the Director. With regard to Dr. Weinstein, my understanding is that although she is no longer an employee of the agency, she maintains an office and a presence there, albeit in a volunteer capacity. That being the case, her affiliation with the agency is sufficiently close for me to believe that her participation in the adjudication would also be a conflict of interest. The same is true for Dr. Bryant, who I understand collaborates with certain ADH divisions, and Dr. Yamauchi, who volunteers on the agency's influenza team.

If there are additional members of the Board who are also agency employees or who are closely affiliated with the Department of Health, I assert that they should be disqualified also on the same basis.

Respondents are entitled to a neutral, impartial adjudication, which I do not believe can be achieved if the above-mentioned members participate.

Thank you for your attention to this matter.

Cordially,

Bettina E. Brownstein

Bettina E. Brownstein

State of Arkansas

County of Pulaski

SUBSCRIBED AND SWORN TO before me, a notary public, within and for said county and state.

My Commission Expires: 12/31/2025

(Seal or Stamp)

REPRESENTATIVE
Robin Lundstrum
P. O. Box 14
Elm Springs, Arkansas 72728-0014

479-957-1959 Business
479-248-1080 FAX
robin.lundstrum@arkansashouse.org

DISTRICT 87

Counties:
Part Benton
Part Washington

COMMITTEES:

Public Health, Welfare and Labor
Health Services Subcommittee

Vice Chairperson,
Insurance and Commerce
Chairperson,
Insurance Subcommittee

Joint Committee on Energy

RECEIVED
OCT 24 2018
LEGAL DIVISION

STATE OF ARKANSAS

House of Representatives

October 23, 2018

Arkansas Department of Health
4815 West Markham
Little Rock, AR 72205

Dear Members of the State Board of Health:

I am writing in regards to the matter of Arkansas Department of Health v. Little Rock Family Planning Services, Inc. and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains.

As a sponsor of Act 1086 of 2015 and Act 383 of 2017, I can speak with authority about the wording and intent of these laws regarding informed-consent for an abortion and the authority of the Arkansas Department of Health.

I sponsored these laws to prevent abortion providers from creating a financial incentive for women to have an abortion. The laws ensure that women seeking an abortion have the right to change their minds during the forty-eight hour reflection period. In addition, the laws clearly empower the Arkansas Department of Health with authority to act in the best interest of women by closing any facility that refuses to obey the law.

Act 1086 of 2015 was written to ensure women receive all the facts about abortion, including its risks and alternatives. Prohibiting abortion facilities and their personnel from charging for an abortion or for services related to the abortion before completion of the forty-eight hour reflection period is intended to ensure no woman feels obligated to have an abortion even if she determines abortion may not be the best choice for her.

Act 383 of 2017 was written to help address shortcomings of Act 1086 of 2015. It further clarified that no person or entity—including a doctor, nurse, or volunteer at an abortion clinic—could charge for an abortion or services related to an abortion prior to completion of the forty-eight hour reflection

period. It also amended state law concerning the Department of Health's oversight of abortion facilities by clarifying that the department must revoke or suspend the license of any facility that fails to comply with state law or with state rules or regulations.

These are reasonable laws that promote the safety and welfare of women, and I expect the State Board of Health to follow the law and ensure its enforcement as intended.

Thank you.

Sincerely,

Robin Lundstrum
State Representative
District 87

QUARTERLY MEETING
ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH,

PETITIONER,

VS.

LITTLE ROCK FAMILY PLANNING SERVICES AND PLANNED PARENTHOOD OF ARKANSAS, AND EASTERN OKLAHOMA /D/B/A PLANNED PARENTHOOD GREAT PLAINS,

RESPONDENTS.

NUMBER ONE: CONFLICT OF INTEREST.

NUMBER TWO: ABORTION FACILITIES REGARDING PLANNED PARENTHOOD.

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OCTOBER 25, 2018

Arkansas Department of Health

5800 West Tenth Street

Little Rock, Arkansas 72205

10:30 a.m.

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COMMITTEE MEMBERS:

CATHERINE TAPP, PRESIDENT
NATHANIEL SMITH, M.D., MPH, SECRETARY
JAMES ZINI, D.O., PRESIDENT-ELECT
TERRY YAMAUCHI, M.D.
GREG BLEDSOE, M.D.
MARSHA BOSS, PHARM.D.
VANESSA FALWELL, ARPN
PHILLIP GILMORE, PH.D.
LEE JOHNSON, M.D.
THOMAS JONES, R.S.
DAVID KIESSLING, D.P.M.
MIKE RIDDELL, M.D.
SUSAN WEINSTEIN, D.V.M.
SUSAN WARD-JONES, M.D.
ROBBIE THOMAS-KNIGHT, PH.D. (BY TELEPHONE)
BEVERLY FOSTER, D.C. (BY TELEPHONE)
GLEN "EDDIE" BRYANT, M.D. (BY TELEPHONE)

COMMITTEE MEMBERS NOT PRESENT:

MIRANDA CHILDS-BEEBE, D.D.S
LAWRENCE BRADEN, M.D.
PERRY AMERINE, O.D.
ALAN FORTENBERRY, P.E.
ANTHONY HUI, M.D.

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A P P E A R A N C E S:

ON BEHALF OF THE ARKANSAS DEPARTMENT OF HEALTH:

LAURA KEHLER SHUE, ESQUIRE
REGINALD ROGERS, ESQUIRE
Arkansas Department of Health
Office of Chief Counsel
4815 West Markham, Slot 31
Little Rock, Arkansas 72205

ON BEHALF OF NUMBER TWO:

BETTINA E. BROWNSTEIN, ESQUIRE
Attorney at Law
904 West Second Street
Second Floor
Little Rock, Arkansas 72201

TRANSCRIPTIONIST:

WAUNZELLE P. PETRE, CCR
Post Office Box 1027
Little Rock, Arkansas 72203-1027

---o---

GUESTS PRESENT:

STEPHANIE WILLIAMS, DEPUTY DIRECTOR
NAMVAR ZOHOORI, M.D., CHIEF SCIENCE OFFICER
REGINALD ROGERS, DEPUTY COUNSEL
VICKI PICKERING, ADMINISTRATIVE LAW JUDGE
BROOKS WHITE, ADMINISTRATIVE LAW JUDGE
JANE GASKILL, ATTORNEY
RENEE MALLORY, DIR., CENTER FOR HEALTH PROTECTION
GREG BROWN, DIR. CENTER FOR TRAUMA
JAMES BLEDSOE, M.D., CHIEF PHYSICIAN SPECIALIST
DON ADAMS, DIR., CENTER FOR LOCAL PUBLIC HEALTH
JOSEPH BATES
DOCTOR GLEN BAKER, DIR., PUBLIC HEALTH LAB
SHANE DAVID, PHARM.D., DIR. OF PHARMACY
CONNIE MELTON, BRANCH CHIEF, HEALTH SYSTEMS LICENSING AND REGULATIONS
KELLI KERSEY, SECTION CHIEF
BECKY BENNETT, HEALTH FACILITIES SECTION CHIEF
SHIRLEY LOUIE, DIR., CENTER FOR PUBLIC HEALTH PROTECTION
MARISHA DiCARLO, PH.D., DIR., HEALTH COMMUNICATIONS
MEG MIRIVEL, PUBLIC INFORMATION SPECIALIST
DOCTOR DIRK HASELOW, DEPUTY CHIEF MEDICAL OFFICER
ABBY HOLT, CANCER RESEARCH ADMINISTRATOR, CPHP HEALTH STATISTICS
KRISTYN VANG, CANCER EPIDEMIOLOGIST
BRANDY SUTPHIN, SENIOR EPIDEMIOLOGIST
LYNDA LEHING, BRANCH CHIEF, HEALTH STATISTICS
JESSICA UPCHURCH, ADMINISTRATIVE SPECIALIST
ROSE MIMMS, ARKANSAS RIGHT TO LIFE
DEBORAH BRUERMAN, FAMILY COUNSEL
TONYA OSAGIE, PHASE ONE SCHOOL OF COSMETOLOGY

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(None marked.)	

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P R O C E E D I N G S

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SECRETARY SMITH: Before we begin our official agenda, because there is a letter that we received, and I would like you to explain that to us, and I think you had some comments you were going to make about, more broadly about conflicts of interest and recusals.

MS. SHUE: Yes. Thank you, Doctor Smith. Thank you, Doctor Smith. I'm Laura Shue, and I am general counsel for the Department of Health.

I passed out a letter that was received by Representative Lundstrom. I was basically serving as a messenger, providing the mail to you. That was with regard to something that we have on the agenda today, you can read that for yourselves.

We do have a vote today that may be considered by some to be controversial and

we have had some concerns and some requests for disqualification of certain board members.

We've tried to make sure that all those board members were given a heads-up on that request prior to the meeting. And an abstention or a disqualification is a personal matter for yourself as an individual board member for your consideration.

If you feel that you are personally interested in this matter to where that it would make you biased, and you are personally interested in any matter that is before the Board, and you feel like you need to disqualify yourself, you may do so. You are not required to do so. That is a personal matter for you to consider before any vote before the Board. And so, before the vote, we may have any abstentions recorded for the record. And so, that would be a matter before the vote would be taken up.

Yes?

SECRETARY SMITH: Laura, I have a

question. And I know you have already answered this to me, or addressed it when I asked you personally. But for the sake of -- as one of those who has been asked to recuse myself, you know, the basis was that it pertained to the Department of Health, that I serve as director of. And that goes for all those who are present or past employees of the Department of Health, County Health officers, others who interact with the Department of Health in some way. By that reason, I should recuse myself from virtually everything that we do every meeting, because essentially all of it pertains to the Arkansas Department of Health.

Can you help walk me and the others through how we would -- how we would try and sift that out?

MS. SHUE: Again, Doctor Smith, that is a reason to consider whether or not your personal interests are going to influence your vote, and whether or not you feel like you cannot put on your board member hat versus your department director hat.

And the difficulty in some of those requests for disqualification is that several of the board members do have connections, whether distant or direct. If there is a pecuniary interest, a direct interest in a certain matter, a board member may feel that they need to recuse.

If they have a personal bias towards a certain matter, they may feel like they need to abstain. But again, it's up to the individual board member.

Yes?

Doctor YAMAUCHI: I also was named or listed as an individual they don't like to vote, so I was trying to think what my conflicts were, and I -- you know, I don't get paid, I don't have an office -- and people don't listen to me anyway, so I just wondered, as I thought about it, I just was thinking that perhaps just being listed has some negative connotations, and I should recuse myself just because I was listed. Now, what is the legality of that?

MS. SHUE: Again --

DOCTOR YAMAUCHI: I don't see that I

have any conflicts, but I don't want to poison the issue by being listed and participating.

MS. SHUE: Again, Doctor Yamauchi, I appreciate your concern. It's an individual decision, and I hate to keep repeating myself. But you know, obviously you all have connections to the Department, whether distant or direct, and if you feel like you were -- a direct interest in a particular matter would influence your vote, and you feel like you may be different than all the other board members as far as your personal feeling or direction on a personal matter, then perhaps you would want to abstain.

Everyone here in the room has some connections to the Department of Health and their decisions, so your connection to the Department of Health does not necessarily disqualify you from making decisions on the Board.

SECRETARY SMITH: And for the record, I listened to Doctor Yamauchi.

BOARD MEMBER TOM JONES: I would like to say something myself, Tom Jones. I am

probably as far away from the medical end of this situation as I could be, being in the environmental, soon to be in environmental 45 years in January. So, I think I would be here as a Richardson's RIA (phonetic) and a citizen, not medically oriented. So, I would like to participate.

MS. SHUE: That's definitely your decision, and we can get to that when we get to that section on the agenda. Prior to that, we need to address new business...

(END 24:00 - START 26:00)

NUMBER TWO

MS. SHUE: Again, Laura Shue, general counsel for the Department. The Board was provided with materials prior to this meeting. As you may recall, in March of 2018, the Department investigated a complaint that three facilities that were represented by the respondents were noncompliant with payment delay. The Department found the complaint to be substantiated and cited the respondents for deficiencies under the law. And after notice was provided for the basis for the

agency action from the citations, the respondents appealed.

Today, we are asking you to make a determination based upon the written pleadings alone. There will be no fact finding or oral argument. After thoughtful consideration of the three briefs and the materials submitted to you prior to this meeting, the Board was going to vote on whether the Department's deficiency citations should be upheld.

If there is a motion to approve and accept the deficiency vote "Aye" you will be voting in favor of upholding the deficiency citations. If you vote "No," you will be voting to reject the deficiency findings.

And that is my presentation. Thank you.

DOCTOR THOMAS-KNIGHT: This is Robbie Thomas-Knight. Catherine, may I ask a question?

PRESIDENT TAPP: Of course, go ahead.

DOCTOR THOMAS-KNIGHT: Excuse me. I wanted to know, why we deviated from our usual process of having a subcommittee that

is watching this hearing closely, and then makes a recommendation. My question is, why did you deviate from our usual process?

MR. ROGERS: If I may, Madam President, Laura was not here, and I was -- and Robert Brech, the former general counsel and I, discussed this matter. And he discussed it with opposing counsel, Ms. Brownstein. And the facts are not in dispute. Normally we would have a committee to do fact finding. But since the facts were not in dispute, it would be duplicitous to have a hearing before a committee and then a hearing before you to go over facts that aren't in dispute.

So, my understanding is that the decision was to submit this to the full board and so it saved time and was more efficient. And Laura was not here at the time, and so she can't speak to any of that.

DOCTOR THOMAS-KNIGHT: I see. Thank you. Thank you, Mr. Rogers. I do appreciate that. Would you say again what we would be voting on, though? I'm sorry, I don't understand what we are being asked to vote on.

MS. SHUE: Yes. Again, this is Laura Shue, general counsel. Today, we are asking you after thoughtful consideration of the three briefs and materials submitted to you prior to this meeting, you are going to be voting on whether the Department's deficiency citations should be upheld. If there is a motion to uphold this deficiency citations, you will -- if you vote "Aye," you will be voting in favor of upholding the deficiency citations. If you vote "No," you will be voting to reject the deficiency findings.

DOCTOR THOMAS-KNIGHT: Laura, again, I am sorry, I need help on this. Okay. We are just -- we are not voting on the constitutionality of it?

MS. SHUE: Correct.

DOCTOR THOMAS-KNIGHT: Is that true?

MS. SHUE: Correct.

DOCTOR THOMAS-KNIGHT: Because that is a -- that is a very, very complex system.

MS. SHUE: Correct.

DOCTOR THOMAS-KNIGHT: You know, things are -- if I read this three-quarters of a

tenth of that document, I really -- gee, I'm no lawyer. I don't know how we are supposed to do that.

MS. SHUE: Yes. And we wanted to provide materials to you as quickly as possible. This administrative body doesn't have the authority to determine the constitutionality of the statute, but in order to preserve the constitutional questions for appeal, those issues were included in the briefs, along with the other claims.

The Administrative Procedure Act gives a party that is adversely affected by an agency adjudication, the opportunity to seek judicial review of this agency action, and review is offered after a party has exhausted its remedies at the administrative level.

So, we are giving the parties an opportunity to exhaust all their remedies, and this adjudication or determination would give the parties an opportunity to appeal and go to the judicial system.

DOCTOR JOHNSON: May I ask a question?

MS. SHUE: Sure.

DOCTOR JOHNSON: This is Lee Johnson, I have a question or a point of clarification. So, when you said there was no disputing the facts of the case, in other words, the agencies didn't come out and say, "No, we didn't do this."

BOARD MEMBER: Right.

DOCTOR JOHNSON: They said, "Sure, we did it." And their point is that this is unconstitutional, the law that has been passed is unconstitutional. The law itself, to me, seems relatively clear with direction to the Board in the sense that it says that you can't charge for these services before the 48 hours have passed, correct? And then, they are not saying they did this, they said they did charge for these services, is that -- when you say they don't dispute the facts, is that correct?

MR. ROGERS: I don't mean to speak for them, but that's our understanding.

DOCTOR JOHNSON: That's your understanding. I mean, one way they can argue it is to say, "Hey, we weren't doing

that," they have not said that, correct?

MR. ROGERS: That's correct.

MS. SHUE: Correct.

DOCTOR JOHNSON: Their argument is not that we didn't violate the statute, their argument is that -- now, I'm just trying to clarify --

MS. BROWNSTEIN: I think I need an opportunity to --

MS. SHUE: Sure.

MR. ROGERS: We tried to limit this to the pleadings, and I don't mean to stand in for Laura, but she was -- she has only been here two and a half weeks.

DOCTOR JOHNSON: Sure.

MR. ROGERS: The matter is before you on the pleadings. I have been advised that it is -- if I have to respond, then the other side needs to respond. And so, I don't mean to cut off your questions, but make you aware of that.

DOCTOR JOHNSON: No, I'm saying --

MR. ROGERS: So --

DOCTOR JOHNSON: I'm just trying to understand what we are -- let's just say

it's --

MR. ROGERS: The facts are not in dispute, yes, sir.

DOCTOR JOHNSON: I'm trying to understand what exactly we are voting on and what the consequences of that vote is.

MR. ROGERS: Yes, sir.

DOCTOR JOHNSON: Many times when we vote on these types of things, as it was mentioned, there has been a committee hearing, we have had a chance to get more information from our peers. So, it's a little bit unusual for a vote, especially when it has the feeling of something that can be consequential and come to us without some sort of committee meeting certainly is a precedence.

Usually as well, when we vote on something like this, there are some sort of punitive consequences that have been decided on at a subcommittee level.

And they give examples for, in essence, ones how much to suspend a license for a period of time or to require some sort of remedial, too great an area, saying -- and

maybe I missed that in this process, but in the event that we vote to uphold the findings, what then happens, other than the citations being issued, what are the other consequences of that from the standpoint of the Board of Health?

MS. BROWNSTEIN: We will appeal.

MR. ROGERS: They will appeal.

DOCTOR JOHNSON: I understand. So, we -- is there a --

MR. ROGERS: Doctor?

DOCTOR JOHNSON: Yeah?

MR. ROGERS: The deficiency letter is before you, you either accept it or you don't.

DOCTOR JOHNSON: I understand. I understand.

MR. ROGERS: And I don't -- I mean, otherwise we will get into more argument.

DOCTOR JOHNSON: I understand. I'm not trying to discuss it any more. I'm just trying to understand it.

MR. ROGERS: Yes, sir. Those are all fine questions. I apologize for the process, but we -- this is the way we

thought would best handle it. And perhaps, there could have been a committee version. But really, there is no dispute on the facts. But they have stopped payment, I mean, they are not -- they are no longer doing what they were doing.

DOCTOR JOHNSON: I see.

MR. ROGERS: But they are waiting on this decision.

DOCTOR JOHNSON: I understand. I understand.

DOCTOR THOMAS-KNIGHT: Excuse me. That is to say they are waiting on what decision?

BOARD MEMBER: That's the respondents --

MR. ROGERS: Well, the Planned Parenthood. Ms. Brownstein is available for questions. But again, we are trying to do this on the pleadings. But she is available and ready to respond.

MS. SHUE: And again, this is Laura Shue, general counsel. This was an agreement of the parties, and we both agreed to proceed in this manner. Obviously, this was done this summer prior to my service.

We are just trying to provide you all with the information and give you all an opportunity to review the materials. But we are relying on our written briefs, there is not to be any oral argument or fact finding today.

PRESIDENT TAPP: Any other questions? Okay. Laura, did you say something?

DOCTOR RIDDELL: I have a question. Just so I understand, in order to find with Act 1086, and the 48 hour law, it required provision of an ultrasound. And that was -- I guess it was decided on the three facilities it mentioned. It was their position whether to do that at the first or second visit.

In order to really comply with the law, though, it made it pretty much common sense for them to obtain the ultrasound at the first visit, so that cardiac activity could be verified, and the law met.

So, that means that the -- there the majority of the cost incurred by these facilities that they are trying to obtain are for the ultrasound services that are

mandated by the law? Because it kind of puts them in a double bind situation in my opinion, and I'm trying to understand.

DOCTOR THOMAS-KNIGHT: I agree with him, too.

MS. SHUE: What is before the Board today is -- are the three briefs, and we would just direct you to the three briefs, the time line, the procedural history. The Department found the complaint to be substantiated and cited the respondents for deficiencies. And that was under the law, we have an agreement between the parties to present this matter before the Board in this matter.

And so, we are just asking you to consider, either accept or reject the deficiency findings today.

PRESIDENT TAPP: Do you want to proceed with collecting the board members who have abstained?

MS. SHUE: Yes. As a reminder prior to the vote, you will need to determine whether you as an individual board member will need to abstain from voting by the nature of your

connections to the Department. You may not necessarily have a bias, generally a board member should abstain from voting, whether you have -- whenever you have an interest in the outcome that directly affects you personally.

Abstentions do not count. If you abstain, you have not voted, even if you are present. So, for the record, we would make a note of the abstentions.

PRESIDENT TAPP: We need to have a motion on the floor for a vote.

DOCTOR BLEDSOE: I make a motion we vote.

PRESIDENT TAPP: Is there a second?

DOCTOR WARD-JONES: Second.

PRESIDENT TAPP: All in favor?

(Eleven board members voted "Aye", with Doctor Sue Weinstein and Doctor Robbie Thomas-Knight voted "Nay.")

PRESIDENT TAPP: Abstention?

PRESIDENT TAPP: Motion passed. Reggie, did you get that?

MR. ROGERS: Three abstentions.

PRESIDENT TAPP: Three abstentions.

DOCTOR YAMAUCHI: I did. And one "Nay".

BOARD MEMBER: Two "Nays".

PRESIDENT TAPP: Raise hands for the "Nays".

(Three Board members abstained from the vote: Doctor Marsha Boss, Doctor Terry Yamauchi, and Vanessa Falwell.)

BOARD MEMBER: There was one on the phone and then Doctor Weinstein.

DOCTOR THOMAS-KNIGHT: Yes. Robbie Thomas-Knight.

BOARD MEMBER: Robbie Thomas-Knight is a?

BOARD MEMBER: A "nay".

PRESIDENT TAPP: Eddie, what was your vote?

DOCTOR GLEN "EDDIE" BRYANT: Yes.

PRESIDENT TAPP: Okay. It looks like the motion passes, as presented before the Board.

(WHEREUPON, the excerpts from the above-entitled hearing were concluded.)

---o---

C E R T I F I C A T E

STATE OF ARKANSAS)
) ss.:
COUNTY OF HEMPSTEAD)

I, WAUNZELLE P. PETRE, Certified Court Reporter and notary public in and for the County of Hempstead, State of Arkansas, duly commissioned and acting, do hereby certify that the transcription correctly reflects the proceedings to the best of my ability from the quality of the audio recording being transcribed.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and affixed my notarial seal, this the 6th day of December, 2018.

WAUNZELLE P. PETRE, CCR
NOTARY PUBLIC IN AND FOR
HEMPSTEAD COUNTY, ARKANSAS
LS Certificate #119

My Commission Expires: December 19, 2019.

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

November 9, 2018

Via Email and Certified Mail
Bettina E. Brownstein
904 W. Second Street, Suite 2
Little Rock, AR 72201

Re: In the Matter of ADH v. LRFPS and PPAEO

Dear Ms. Brownstein:

Please find enclosed the Board of Health's November 8, 2018 order based on the Board's decision at its October 25, 2018, meeting.

If you have any questions, please let me know.

Sincerely,

Laura Kehler Shue
General Counsel
Arkansas Department of Health
4815 West Markham Street, Slot 31
Little Rock, AR 72205-3867
Direct (501) 661-2297
Fax (501) 661-2357

BEFORE THE STATE BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH — PETITIONER

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA D/B/A PLANNED PARENTHOOD GREAT PLAINS — RESPONDENTS

STIPULATED FACTS; CONCLUSIONS OF LAW AND ORDER

STATUTORY AUTHORITY

This Order is issued under the authority vested in the Arkansas State Board of Health, and the State Health Officer of Arkansas by Ark. Code Ann. §§ 20-7-101, 20-7-109 et seq.; Ark. Code Ann. § § 20-9-204 and 205, and § 20-9-302; and by the Arkansas Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.

Pursuant to the parties' stipulated procedure in the Notice of Hearing, and in lieu of an in-person hearing before a subcommittee, the Petitioner, Arkansas Department of Health, and the Respondents, Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains, stipulated to the following facts in written briefs, which were presented to and adopted by the Arkansas Board of Health on the 25th day of October, 2018:

STIPULATED FACTS

1. The Petitioner, the Arkansas Department of Health, received a complaint regarding Respondents' three licensed abortion facilities.

2. In January and February, 2018, Petitioner, the Arkansas Department of Health, investigated Respondents Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma.

3. Following an investigation and document review, on March 13, 2018, the Department advised Respondent, Little Rock Family Planning Services, by letter that it found that Respondents were deficient by violating Ark. Code Ann. § 20-16-1703(d). Specifically, Petitioner found that Respondents had been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight (48) hour reflection period, in violation of the law.

4. Following an investigation and document review, on March 23, 2018, the Department advised Respondent, Planned Parenthood's centers in Fayetteville and Little Rock, by letter that it found that Respondents were deficient by violating Ark. Code Ann. § 20-16-1703(d). Specifically, Petitioner found that Respondents had been requiring and obtaining payment for services provided in relation to abortion before the expiration of the forty-eight (48) hour reflection period, in violation of the law.

5. From the citations, the Respondents appealed to the Board of Health.

CONCLUSIONS OF LAW

1. Pursuant to the parties' stipulated procedure to provide for a fair hearing by submission of written briefs, the Board reviewed the written briefs submitted by the Department and Respondents, which examined the Department's authority and applicability of Ark. Code Ann. § 20-16-1703(d) to the Respondents' actions. Interpretation of a statute is a question of law.

2. After review and consideration of the agreed facts and questions of law, the Board of Health voted during its October 25, 2018, meeting, and affirmed the Department's deficiency

findings and its interpretation of the law. The Board of Health agreed with the Department's written arguments and affirmed the determination that Respondents' conduct fell within the terms of the statute, Ark. Code Ann. § 20-16-1703(d).

3. To the extent that Respondents raised constitutional claims against enforcement of the state statute, the Department responded that the statute is presumed to be constitutional and enforced the law. While noting that the Board of Health does not have authority to declare unconstitutional a statute that the Department was required to enforce, the Respondents' constitutional claims were reviewed and considered by the Board during the review process.

4. To the extent that Respondents raised a tortious interference with contract claim, by upholding the deficiencies based on the Department's arguments, the Board affirmed the Department's assertion that sovereign immunity would preclude that claim.

ORDER

After due consideration and deliberation, the Board of Health affirmed that the stipulated facts against the Respondents were proven as deficiencies and that the Respondents' actions were in violation of Ark. Code Ann. § 20-16-1703(d). The resulting order concerns the rights of the Respondents and is a final agency action. This Order shall become final unless appealed in accordance with Ark. Code Ann. § 25-15-212 within thirty (30) days after service of the Board's decision.[1]

---

[1] The procedures for review of the Department's decision under Ark. Code Ann. § 20-9-302 (b) provide for finality fifteen (15) days after the decision is sent by certified mail. See also District Court Rule 9(f)(1) Appeals to Circuit Court-Administrative Appeals (noting that if an applicable statute provides a method for filing an appeal from a final decision of any agency and a method for preparing the record on appeal, then the statutory procedures shall apply). However, due to the nature of these proceedings, it appears that any judicial review procedures under the Administrative Procedure Act would apply.

IT IS SO ORDERED this 8 th day of November, 2018.

Catherine Tapp
President
Arkansas State Board of Health

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Bettina E. Brownstein
904 W. Second Street, Suite 2
Little Rock, AR 72201

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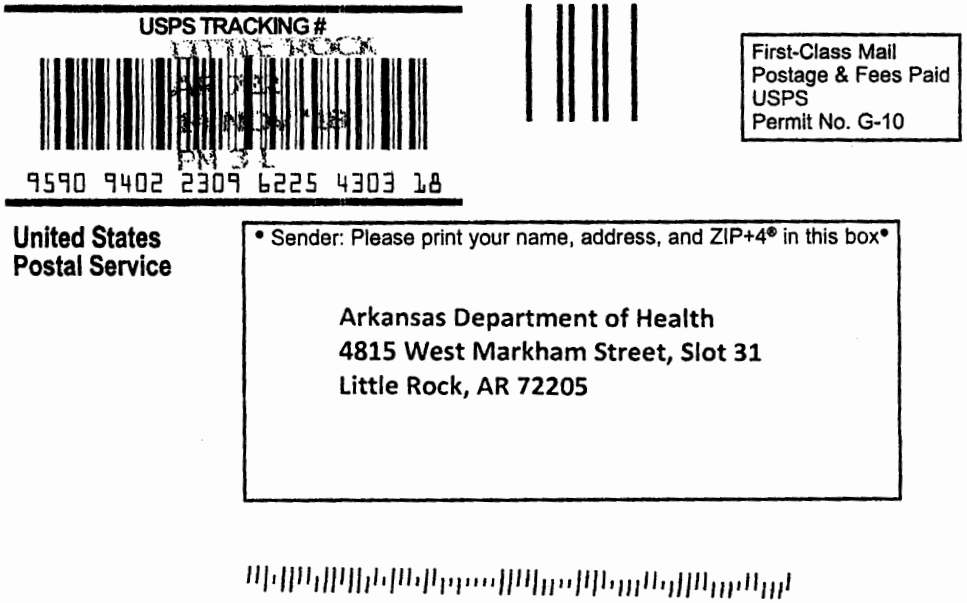
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Arkansas Department of Health
4815 West Markham Street, Slot 31
Little Rock, AR 72205

Bettina E. Brownstein
904 W. Second St
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Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com
November 14, 2018

Via EMAIL

Re: Freedom of Information Act Request/Documents pertaining to Acts 1086 and 383

Ms. Laura Shue, Esq.
General Counsel
Arkansas Dept. of Health
4815 W. Markham St.
Little Rock, Arkansas 72205
Email: Laura.Shue@arkansas.gov

Dear Laura:

Respondents submit this Motion to Compel Order that Complies with Arkansas Law.

A hard copy will be mailed to you today.

Cordially,

Bettina E. Brownstein, Counsel for Respondents

BEFORE THE ARKANSAS BOARD OF HEALTH

IN THE MATTER OF:
ARKANSAS DEPT. OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

Motion to Compel Order that Complies with Arkansas Law

Respondents, pursuant to the Administrative Procedures Act, Ark. Code Ann. §25-15-201 *et seq*., submit this motion to compel Petitioner to issue a revised order that complies with this Act and Arkansas law.

1. On November 8, 2018, the Arkansas State Board of Health (the "Board") issued an order in the captioned matter which purports to be a final agency action. Order, p.3.

2. The order recites that it was issued, *inter alia*, under the Arkansas Administrative Procedures Act, A.C.A. §25-15-201 *et. seq.* (the "Act" or the "APA"). However, the order fails to comply with this Act, which requires that "there be findings of fact and conclusions of law separately stated." §25-15-210. The order does not do this. It merely recites that "after consideration of the agreed facts and questions of law, the Board of Health voted . . . and affirmed the Department's deficiency findings and its interpretation of the law. The Board of Health agreed with the Department's written arguments and affirmed the determination that Respondents' conduct fell with the terms of the statute, Ark. Code Ann. § 20-16-1703 (d)."

3. The order is insufficient to permit judicial review of the Board's decision to uphold the deficiency citations that are the basis of the administrative appeal. It does not permit a

reviewing court to address and rule on each of the issues raised by Respondents in their administrative appeal.

4. It is well-established that Arkansas law requires the Board to make specific finding on individual issues raised by a respondent in an administrative appeal, including alleged constitutional issues, before a reviewing court will address them. *See Hanks v. Sneed*, 235 S.W. 3d 883, 890, 366 Ark. 371 (Ark. 2006) (citing *Arkansas Contractors Licensing Bd. v. Pegasus Renovation Co.*, 347 Ark. 320 (2001) (An appellant must obtain a ruling from the Board in order to preserve an argument, even a constitutional one, for an appeal from an administrative proceeding.))

3. Petitioners' initial brief raised the following eight, separate points of appeal:

(1) The statute upon which the citations are based, A.C.A. § 20-16-1703(d), as now interpreted by ADH, ("the Payment Ban"), violates the takings clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 22 of the Arkansas Constitution;

(2) The Payment Ban violates the equal protection clauses of the 5th and 14th Amendments of the U.S. Constitution and Article 2, § 18 of the Arkansas Constitution;

(3) The Payment Ban violates the privacy rights of Respondents' patients, as guaranteed by the U.S. and Arkansas Constitutions;

(4) The Payment Ban violates the Contracts Clause of the U.S. Constitution, Art. 1, § 10.

(5) The Payment Ban constitutes tortious interference with contract in violation of Arkansas common law;

(6) ADH exceeded its authority in issuing the deficiency citations absent a regulation or rule prohibiting this conduct, and, under A.C.A. § 20-7-109(c), its interpretation of the law as prohibiting payment for services provided at a patient's first visit until the lapse of 48 hours interferes with the practice of medicine;

(7) Issuance of the deficiency citations was arbitrary and capricious, as ADH had previously found no violation of law in LRFPS's practice of charging for services provided at the patient's first visit before the lapse of 48 hours; and

(8) Issuance of the deficiency citations was arbitrary and capricious as PPAEO's practice of gathering credit card information at the first visit and then charging patients for services only after a delay of at least 48 hours complies with A.C.A. § 20-16-1703(d).

4. Petitioner, in its response to Respondents' initial brief, responded separately to all of the non-constitutional bases for the appeal (with the exception of number 6, which it did not respond to at all.) However, the order completely fails to respond to any of these separate bases.

5. Respondents intend to raise all the above-enumerated issues on appeal to the circuit court and, under the APA and Arkansas law, are entitled to an order from Petitioner that permits the reviewing court to address and rule on each of these issues.

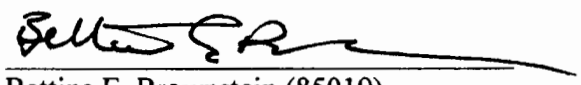
5. Respondents presented facts relevant to each point of appeal via six affidavits. None of these facts were controverted by the Department of Health. Moreover, the department presented no additional facts beyond the five the order characterizes as "Stipulated Facts." However, the order completely ignores the uncontroverted facts presented via Respondents' affidavits.

6. The order labels certain facts "Stipulated Facts." This is incorrect. While Respondents do not contest these facts, they were not stipulated to by Respondents. Moreover, they are incomplete, as there are many additional facts, as contained in the affidavits of Melanie Helsinki, Nathan Johnson, Lori Williams, and Dr. Mick Tilford, that should be considered "stipulated" because they were not disputed by the department. Since they were not controverted by the department, they must be accepted by the Board.

WHEREFORE, Respondents request that this motion be granted and that Petitioner issue a revised order with separately stated conclusions of law and findings of fact that support each conclusion on all eight points of appeal, including the constitutional issues, raised by Respondents in their appeal.

In addition, Respondents renew their request that the deficiency citations contained in the Statements of Deficiencies issued to Respondents be dismissed and that their Motion to Dismiss be granted.*

Respectfully submitted:



Bettina E. Brownstein (85019)
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904 W. Second St., Suite 2
Little Rock, Arkansas 72201
Tel: (501) 920-1764
E-mail: bettinabrownstein@gmail.com

*Respondents are in receipt of notices from Petitioner that it deemed affidavits submitted by Respondents in their administrative appeals to be Plans of Correction of the alleged deficiencies contained in the Statements of Deficiencies that are the subject of their appeal. Respondents do not consider these unilateral actions by Petitioner to constitute any type of agreement by them as to the validity of the defiency citations at issue nor as any type of waiver of Respondents' challenges to the legality of the citations.

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS

_____ DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA DBA PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v.

ARKANSAS BOARD OF HEALTH — **DEFENDANT**

APPEAL FROM ADMINISTRATIVE DECISION

Plaintiffs Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains appeal from an order of the Arkansas Board of Health ("ÄBOH") issued November 8, 2018 which is adverse to Plaintiffs. Plaintiffs' research indicates that the order is insufficient under the law to permit judicial review of the order and have thus filed a motion with the ABOH requesting that it revise its order. However, to prevent any waiver or default of their ability to appeal, Plaintiffs file this timely notice of appeal. In the event Defendant revises its order, as requested by Plaintiffs, Plaintiffs is likely to file an amended notice of appeal.

Designation and transmittal of the record is governed by Ark. Code. Ann. §25-15-212, which requires Defendant to transmit at its cost the entire record of the proceedings below for this appeal.

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

December 3, 2018

Via Email and Certified Mail
Bettina E. Brownstein
904 W. Second Street, Suite 2
Little Rock, AR 72201

Re: In the Matter of ADH v. LRFPS and PPAEO

Dear Ms. Brownstein:

Please find enclosed the Board of Health's December 3, 2018 order.

If you have any questions, please let me know.

Sincerely,

Laura Kehler Shue
General Counsel
Arkansas Department of Health
4815 West Markham Street, Slot 31
Little Rock, AR 72205-3867
Direct (501) 661-2297
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BEFORE THE STATE BOARD OF HEALTH

IN THE MATTER OF:

ARKANSAS DEPARTMENT OF HEALTH **PETITIONER**

V.

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA D/B/A PLANNED PARENTHOOD GREAT PLAINS **RESPONDENTS**

ORDER

On October, 25, 2018, after review and consideration of the complete record of undisputed facts, questions of law, and legal arguments submitted by the parties, the Board of Health affirmed the Department's deficiency findings and its interpretation of a statute, specifically, Ark. Code Ann. § 20-16-1703(d). In consideration of the Respondents' November 14, 2018, motion to compel order that complies with Arkansas law, the original order, dated November 8, 2018, is sufficient. Therefore, the motion is denied.

IT IS SO ORDERED this 3rd day of December, 2018.

Catherine Tapp
President
Arkansas State Board of Health

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v. **No. 60CV-18-8090**

ARKANSAS BOARD OF HEALTH — **DEFENDANT**

MOTION FOR MORE DEFINITE STATEMENT AND INCORPORATED BRIEF

Pursuant to Arkansas Rule of Civil Procedure 12(e), Defendant Arkansas Board of Health respectfully requests that the Court order the Plaintiffs to file a more definite statement.

1. On November 26, 2018, the Plaintiffs filed a document titled "Appeal from Administrative Decision," which was docketed as a "Complaint/Petition."

2. Under Ark. R. Civ. P. 12(e), a party may move for a more definite statement "[i]f a pleading to which a responsive pleading is permitted is so vague or ambiguous that a party cannot reasonably be required to frame a responsive pleading."

3. Here, the Plaintiffs' filing consists of two paragraphs that merely state legal conclusions and is otherwise so vague that the Board is unable to frame a responsive pleading.

4. The Plaintiffs' filing does not make any "demand for the relief to which the [Plaintiffs] consider[] [themselves] entitled." Ark. R. Civ. P. 8(a). Even worse, it contains no allegations of any facts at all, much less any allegations of "facts showing that the court has

jurisdiction of the claim and is the proper venue and that the [Plaintiffs are] entitled to relief." *Id.*

5. A more definite statement should include, among other things, all asserted bases for this Court's jurisdiction, the Plaintiffs' specific legal claims, the relief that the Plaintiffs seek in this case, and the factual allegations establishing each of these.

Therefore, the Arkansas Board of Health respectfully requests that this Court order the Plaintiffs to make a more definite statement.[1]

Respectfully submitted,

LESLIE RUTLEDGE
Attorney General

By: */s/ Michael A. Cantrell*
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Attorneys for Arkansas Board of Health

[1] This motion relates only to the Plaintiffs' November 26, 2018, filing. Out of an abundance of caution, to avoid waiver under Ark. R. Civ. P. 12(h)(1) or otherwise, the Board asserts the defenses of sovereign immunity and pendency of another action between the same parties arising out of the same transaction. The Board reserves the right to assert other defenses.

CERTIFICATE OF SERVICE

I, Michael A. Cantrell, hereby certify that on December 26, 2018, I filed the foregoing with the Clerk of the Court using the electronic filing system, which shall send notification to all counsel of record.

/s/ Michael A. Cantrell
Michael A. Cantrell

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS

SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA DBA PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v.

ARKANSAS BOARD OF HEALTH — **DEFENDANT**

PLAINTIFFS' RESPONSE TO MOTION FOR A MORE DEFINITE STATEMENT

On November 26, 2018, Plaintiffs filed a timely notice of appeal to this Court from an administrative decision of the Arkansas Board of Health ("ABOH"). That notice of appeal was filed electronically as an administrative appeal document, and explains in its short text that it is a document triggering an appeal from an administrative decision of the Defendant Arkansas Board of Health ("ABOH"). That filing was also accompanied by a civil cover sheet that identifies the filing as a notice triggering an appeal from an administrative decision.

Despite the fact that there can be no confusion that Plaintiffs' November 26, 2018, filing was a notice of an administrative appeal, Defendant has filed a motion for a more definite statement under Ark. R. Civ. P. 12 (e), alleging that Plaintiffs' notice is somehow deficient since it does not comply with Ark. R. Civ. P. 8(a). Rule 8(a), however, is not applicable to administrative appeals, which are instead governed by Ark. R. Civ. P. 9 (f) "Appeals to Circuit Courts." Defendant has provided no authority for a notice of administrative appeal to be governed by Rule 8(a) or to include the information Defendant requests. Nor has Defendant provided any authority for its motion under Ark. R. Civ. P. 12(e), which does not apply to such a

notice, because it is not "a pleading to which a responsive pleading is permitted." Ark. R. Civ. P. 12(e).

Rule 9(f) provides the following:

> (f) *Administrative Appeals.*
>
> (1) If an applicable statute provides a method for filing an appeal from a final decision of any governmental body or agency and a method for preparing the record on appeal, then the statutory procedures shall apply.
>
> (2) If no statute addresses how a party may take such an appeal or how the record shall be prepared, then the following procedures apply.
>
> (A) *Notice of Appeal.* A party may appeal any final administrative decision by filing a notice of appeal with the clerk of the circuit court having jurisdiction of the matter within thirty (30) days from the date of that decision. The notice of appeal shall describe the final administrative decision being appealed and specify the date of that decision. The date of decision shall be either the date of the vote, if any, or the date that a written record of the vote is made. The party shall serve the notice of appeal on all other parties, including the governmental body or agency, by serving any person described in Arkansas Rule of Civil Procedure 4(d)(7), by any form of mail that requires a return receipt.

In contrast, Rule 8(a), by its own terms, applies only to complaints, counterclaims, crossclaims and third-part complaints and not to administrative appeals to circuit court.

In their notice of appeal, Plaintiffs have fully complied with both Rule 9(f) and the Arkansas Administrative Procedures Act, Ark. Code Ann. §25-15-200 *et. seq.,* which governs appeals from administrative decisions of the ABOH. Plaintiffs stated that they were appealing from an adverse administrative decision issued November 8, 2018 by ABOH and cited the applicable statute, Ark. Code Ann. §25-15-212. This is sufficient under both Rule 9(f) and §25-15-212.

Defendant complains it is unable to frame a response to the notice of appeal, but under §25-15-212, no responsive pleading is provided for. Judicial review generally is confined to the

administrative record and the Court, if requested, may hear oral argument and receive written briefs. Ark. Code Ann. §25-15-212 (g).

Plaintiffs have separately served and filed a Petition for A Writ of Mandamus in this Court, requesting the Court to order Defendant to issue a revised order that fully complies with. Ark. Code Ann. §25-15-210, so as to permit complete judicial review of the issues raised by Plaintiffs before the ABOH. Defendant has no legal basis for its motion, and Plaintiffs are not legally required to provide any more information with regard to their notice of appeal.

WHEREFORE, Plaintiffs respectfully request that the Motion for A More Definite Statement be denied.

Dated: January 7, 2019.

Respectfully submitted:

/s/Bettina E. Brownstein
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Tel: (501) 920-1764
Email: bettinabrownstein@gmail.com

Attorney for Plaintiffs

On Behalf of Arkansas Civil Liberties Foundation, Inc.

CERTIFICATE OF SERVICE

I, Bettina E. Brownstein, do hereby certify that on January 7, 2019, I filed the forgoing with the Clerk of the Court using the electronic filing system, which will notify all counsel of record.

/s/Bettina E. Brownstein
Bettina E. Brownstein

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA dba PLANNED PARENTHOOD GREAT PLAINS — **PLAINTIFFS**

v. **No. 60CV-18-8090**

ARKANSAS BOARD OF HEALTH — **DEFENDANT**

RESPONSE IN OPPOSITION TO PLAINTIFFS' PETITION FOR WRIT OF MANDAMUS

A petitioner who lacks a clear and certain right to the relief it requests cannot prevail on a petition for a writ of mandamus. Here, the Plaintiffs request an order compelling the Board of Health to render rulings that are, variously, precluded by law, already rendered, or legally unnecessary. The Plaintiffs utterly fail to show any right to relief whatsoever, let alone a right that is clear and certain. This Court should deny their petition.

FACTS AND PROCEDURAL HISTORY

In 2015 the General Assembly enacted the Woman's Right to Know Act.[1] As relevant here, the Act accomplishes two things. First, it requires certain information be provided to a woman at least 48 hours before an abortion is performed. Second, it prohibits an abortion practitioner from requiring or obtaining payment for abortion-related services until that 48-hour reflection period expires. In 2017 the General Assembly amended the Act to prohibit not just *abortion practitioners* but also *abortion facilities* (among others) from

[1] Arkansas Act 1086 of 2015, codified at Ark. Code Ann. §§ 20-16-1701 to 1711. The Act repealed a 2001 act with the same name.

requiring or obtaining payment for abortion-related services until the reflection period expires.[2]

In January and February 2018, the Arkansas Department of Health inspected three licensed abortion facilities run by Little Rock Family Planning Services and Planned Parenthood of Arkansas and Eastern Oklahoma d/b/a Planned Parenthood Great Plains. R.7.[3] The Department discovered that the facilities were not complying with Arkansas's requirement that payment for abortion-related services not be obtained until after the expiration of the 48-hour reflection period. Ark. Code Ann. § 20-16-1703(d). The Department issued letters notifying the facilities of the citations for noncompliance. R.7. The facilities appealed the citations. In lieu of an initial hearing before a subcommittee, the parties agreed to brief the matter and then submit it to a vote by the Board of Health without oral presentation. R.8. The Board voted to uphold the citations, R.223-24, and it issued an order affirming that the facilities had violated Ark. Code Ann. § 20-16-1703(d). R.227-30.

The facilities filed a motion to compel, arguing that the Board's order did not comply with the requirement that "there be findings of fact and conclusions of law separately stated." R.234 (citing Ark. Code Ann. § 25-15-210). The facilities contended that without point-by-point findings on each of its eight points of argument the order is insufficient to permit judicial review of the Board's decision. *Id.* The facilities also filed an appeal of the Board's decision in this Court. R.238. After the Board issued a subsequent order denying the facilities' motion to compel, R.240, the facilities brought this petition for a writ of

[2] Arkansas Act 383 of 2017, modifying language codified at Ark. Code Ann. § 20-16-1703(d).

[3] Record citations are to the administrative record filed on December 17, 2018.

mandamus seeking an order requiring the Board to issue an opinion that, they contend, complies with Ark. Code Ann. § 25-15-212.

STANDARD OF REVIEW

A writ of mandamus is an extraordinary remedy that is appropriate only when a public officer refuses to perform a plain and specific duty that is required by law and requires no exercise of discretion or official judgment. *Parker v. Crowe*, 2010 Ark. 371, at 6. A writ of mandamus is appropriate if: (1) the duty is ministerial and not discretionary; (2) the petitioner has shown a clear and certain right to the relief sought; and (3) there is no other adequate remedy. *Id.* The petitioner carries the burden of showing that extraordinary relief is warranted. *Wallace v. Johnson*, 2018 Ark. 275, at 2.

ARGUMENT

Plaintiffs' petition must be denied because the Board of Health has performed its duty to render a decision in accordance with the law, and Plaintiffs have not met their burden of showing that the Board has failed to perform any ministerial duty to which they have a clear and certain right. In particular, the Plaintiffs have no clear and certain right to additional rulings on the points they raise in their petition.

A final agency decision "shall include findings of fact and conclusions of law, separately stated." Ark. Code Ann. § 25-15-210(b)(2). Here, the Board's November 8, 2018, order separately states findings of fact and conclusions of law. R.227-30. The findings of fact are set forth on pages 1 and 2 of the order under the heading "Stipulated Facts," R.227-28, and the conclusions of law are set forth in a separate section on pages 2 and 3 under the heading "Conclusions of Law." R.228-29. The Board's order complies with the statutory requirement, and this Court should deny the Plaintiffs' petition.

The Plaintiffs' chief complaint is that the Board failed to fulfill a supposed duty to specifically rule on whether the Woman's Right to Know Act violates the U.S. and Arkansas Constitutions. But the only duty the Board has with regard to the Act is to apply it as written by the General Assembly—not to determine whether the General Assembly acted unconstitutionally. "There is simply no administrative procedure available in which [a party] can seek a declaration from the [agency] that a statute it is required to enforce is unconstitutional." *Lincoln v. Ark. Pub. Serv. Comm'n*, 313 Ark. 295, 298 (1993). An agency's reviewing the constitutionality of a statute would violate the separation-of-powers doctrine. *Id.*; *AT & T Commc'ns of The Sw., Inc. v. Ark. Pub. Serv. Comm'n*, 344 Ark. 188, 196 (2001).

Indeed, far from having a ministerial duty to make point-by-point rulings on the Plaintiffs' constitutional claims, the Board is *precluded* from doing so. The law could not be clearer that "an administrative agency lacks the authority to rule on a constitutional argument." *Reed v. Arvis Harper Bail Bonds, Inc.*, 2010 Ark. 338, at 4; *Ark. Tobacco Control Bd. v. Sitton*, 357 Ark. 357, 361-62 (2004) (holding that the Tobacco Control Board "lacks the authority to decide the issue of the unconstitutionality of a statute" and that it "rightly declined to decide the issue of constitutionality").

Next, the Plaintiffs claim that the Board's order ignores their challenges to the validity of the deficiency citations. But this is false. The Board's order expressly states that it reviewed the parties' briefs, "which examined the Department's authority and applicability of Ark. Code Ann. § 20-16-1703(d) to the [Plaintiffs'] actions." R.228. The Board "agreed with the Department's written arguments and affirmed the determination that [Plaintiffs'] conduct fell within the terms of the statute, Ark. Code Ann. § 20-16-1703(d)." R.228. Therefore, the Board has already rendered rulings on these issues.

The Plaintiffs suggest that the Board "ignore[d] the many facts asserted" in their briefing below. Pl. Pet. At 7. But this is not an argument that the Board *failed to include* findings of fact in its final agency decision but an argument that the Board's findings of fact are *wrong*. The Plaintiffs may not obtain ordinary appellate review of the Board's factual findings via the extraordinary remedy of mandamus. *See Arkansas Gen. Utilities Co. v. Smith*, 188 Ark. 413 (1933) (writ of mandamus is unusual and appropriate only when there is no other remedy).

Finally, the Plaintiffs argue that the Arkansas Supreme Court's opinion in *Hanks v. Sneed* necessitates additional rulings on each of their eight points in order for those arguments to be preserved for appeal to the circuit court. 366 Ark. 371 (2006). But the Arkansas Supreme Court has expressly overruled *Hanks* on the very point pressed by the Plaintiffs here. *See Hardin v. Bishop*, 2013 Ark. 395, at 6. *Hardin* held that the Arkansas Supreme Court was *not* precluded from considering issues on appeal that the lower court's summary judgment order had not specifically ruled on. *Id.*

Besides the fact that *Hanks* is no longer good law, that case arose in a completely different procedural context. There, the Arkansas Supreme Court declined to review issues that the circuit court's summary judgment order failed to specifically rule on. 366 Ark. at 381. The Court indicated that to preserve an argument for appeal, the appellant must obtain a ruling below. *Id.* Even before it was overruled, then, *Hanks* related only to issue preservation in an appeal from a circuit court to the Arkansas Supreme Court. The Supreme Court nowhere suggested that the same rule governed an appeal under the Administrative Procedures Act from an agency decision to the circuit court. Therefore, *Hanks* cannot

support Plaintiffs' claim for relief, and Plaintiffs have not shown that additional rulings are required by law.

The Board's order fully complies with the law, and the Plaintiffs have failed to meet their burden of showing a clear and certain right to additional rulings. Therefore, this Court should deny the Plaintiff's petition.

Respectfully submitted,

LESLIE RUTLEDGE
Attorney General

/s/ Michael A. Cantrell
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Attorneys for Arkansas Board of Health

CERTIFICATE OF SERVICE

I, Michael A. Cantrell, hereby certify that on January 16, 2018, I filed the foregoing with the Clerk of the Court using the electronic filing system, which shall send notification to all counsel of record.

/s/ Michael A. Cantrell
Michael A. Cantrell

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
SIXTH DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES and PLANNED PARENTHOOD OF ARKANSAS AND EASTERN OKLAHOMA DBA PLANNED PARENTHOOD GREAT PLAINS	**PLAINTIFFS/ PETITIONERS**
v.	**Case No. 60cv-18-8090**
ARKANSAS BOARD OF HEALTH	**DEFENDANT/ RESPONDENTS**
CATHERINE TAPP, PERRY AMERINE, MARSHA BOSS, GREG BLEDSOE, GLEN "EDDIE" BRYANT, VANESSA FALWELL, ALAN FORTENBERRY, PHILLIP GILMORE, ANTHONY N. HUI, DAVID KIESSLING, CARL MIKE RIDDELL, ROBBIE THOMAS KNIGHT, SUSAN WEINSTEIN, TERRY YAMAUCHI, DR. JAMES ZINI, NATHANIEL SMITH, MEMBERS OF THE ARKANSAS BOARD OF HEALTH, In Their Official Capacities.	**RESPONDENTS**

REPLY TO RESPONSE TO PETITION FOR WRIT OF MANDAMUS

Petitioners Little Rock Family Planning Services ("LRFPS") and Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains ("PPGP") filed their petition for a writ of mandamus because without a writ compelling Respondents to issue an order that sets forth rulings on the individual issues raised by Petitioners in their appeal before the Arkansas Board of Health ("ABH"), including the constitutional ones, this Court and, in the case of a further appeal, the Arkansas Supreme Court, will likely not consider these issues preserved.

Hanks v. Sneed is Still Good Law

Respondents assert that *Hanks v. Sneed*, 235 S.W. 3d 890-91 (Ark. 2006) was overruled by *Hardin v. Bishop,* 430 S.W. 3d 49 (Ark. 2013). This is incorrect. *Hardin* overruled only the holding in *Hanks* that concerned an appeal from a circuit court's grant of summary judgment under Ark. R. Civ. P. 56 and not the holding of *Hanks* that concerned an appeal from an administrative board's decision, specifically the ABH (the same board involved here.) *Hardin,* 430 S.W. 3d at 53-54. The *Hardin* Court cited the language of Rule 56 in ruling that a circuit court is not required to make findings of fact or conclusions of law when ruling on a motion for summary judgment. *Id.* However, the *Hardin* Court explicitly limited the scope of its ruling to rulings in cases involving a motion. *Id.* (Citations omitted.) The petition at issue here does not involve an appeal from a ruling on a summary judgment motion; rather, it concerns an appeal from an administrative order, which is outside the purview of the ruling of the *Hardin* Court and falls squarely within *Hanks*.

In *Hanks*, there were two matters on appeal from the circuit court: (1) the circuit court's ruling on several motions, including Ark. R. Civ. P. 12(b)(6) and summary judgment motions, and (2) an administrative decision of the ABH. *Hanks*, 235 S.W. 3d at 890-91. With regard to the appeal from the ABH's decision, the Court in *Hanks* declined to consider the individual issues raised by appellant Hanks because ABH had not made a ruling on those issues, **including the constitutional ones.** *Id.* It is this aspect of *Hanks* that was not overturned by *Hardin.*

Respondents also wrongly argue that *Hanks* is inapplicable here because it related "only to issue preservation in an appeal from a circuit court to the Arkansas Supreme Court and not to an appeal from an agency decision to the circuit court." Resp. at 5. This too is wrong. In *Hanks*, the Court stated: "When this court engages in judicial review of an agency decision, we review

the decision of the agency and not that of the circuit court." *Id.* at 890. In reviewing the agency decision, the Court found that Hanks had failed to obtain the necessary rulings from ABH and that his arguments (including the constitutional ones) were not preserved. *Id.* The Court stated: "We have held many times that it is the appellant's obligation to raise such matters first to the administrative agency and obtain a ruling." *Id.* (Citation omitted.)

It could not be clearer that *Hanks* pertains to issue preservation for the initial appeal of an agency decision to a circuit court, as well as any ultimate appeal to the Arkansas Supreme Court, because under Ark. Code Ann. § 25-15-212 of the Arkansas Administrative Procedures Act ("APA"), an appeal from an administrative decision may only be made to the circuit court. But even looking at *Hanks* in isolation, the higher appellate court looks to the administrative decision and not the circuit court decision if there is an appeal from the circuit court and still supports Petitioners' need for a sufficient administrative decision. *Id*; *See also Reed v. Avis Harper Bail Bonds, Inc.* 368 S.W. 3d. 69, 72 (Ark. 2004). Thus, *Hanks* absolutely supports Petitioners claim for relief in their petition for a writ to compel an ABH decision that allows the issues raised by Petitioners to be fully preserved for appeal to this Court and on further appeal, if necessary.

Is ABH Required to Rule on Constitutional Issues Raised?

Respondents cite four cases for the proposition that ABH lacked authority to rule on constitutional issues. Resp. at 4. These cases do support this position, but that does not obviate the need for a discrete ruling of lack of authority on each specific constitutional claim, to make clear that Petitioners raised each and received a ruling on each in the ABH. Moreover, three of the four were decided before *Hanks,* and *Reed,* the only case decided after *Hanks,* does not overrule or even mention *Hanks*. *Id.* In its decision that is the subject of this writ, ABH states

that § 20-16-1703(d) is presumed constitutional and recites that it lacks the authority to declare it unconstitutional. R.229. In view of *Hanks*, Petitioners are seeking rulings by ABH on the individual constitutional issues raised so that these constitutional issues are preserved for review in this Court and on appeal to the Arkansas Supreme Court, if necessary.[1]

The ABH Order Does Not Comply with the APA or Hank v. Sneed

Respondents argue that ABH met its ministerial duty under § 25-15-210(b)(2) because in its order there is a section entitled Stipulated Facts and another entitled "Conclusions of Law". Resp. at 3. This is elevating form over substance, as the substance of the order fails to comply with either the APA, which requires findings of fact and conclusions of law separately stated, or precedent from the Arkansas Supreme Court. The order at issue here is similar to the one in *Hanks,* which the Court found insufficient to preserve individual issues for appeal. The Court in *Hanks* found that that the ABH decision, "made no specific finding on the legality of its Rules for Emergency Medical Services" or the "alleged constitutional violations," *Hanks*, 235 S.W. 3d at 890, which absence of constitutional ruling the Court listed for *each* discrete constitutional argument. *Id* Instead, the ABH decision in *Hanks* simply stated that the "ADH has complied with its rules in rendering its decision." *Id.* Just as was the case in *Hanks*, here there is no ruling by ABH on any of the individual issues raised by Petitioners in their administrative appeal. In addition to declining to rule on the constitutional issues, the order at issue here simply states,

> After review and consideration of the agreed facts and question of law, the Board of Health voted during its October 25, 2018, meeting, and affirmed the Department's deficiency findings and its interpretation of the law. The Board of Health agreed with the Department's written arguments and affirmed the determination that the Respondent's conduct fell within the

[1] Petitioners claim that Ark. Code Ann. § 20-16-1703(d) violates the taking clauses of the U.S. Constitution and the Arkansas Constitution; the equal protection clauses of the U.S. and Arkansas Constitutions, the privacy rights of the U.S. and Arkansas Constitutions; and the Contracts Clause of the U.S. Constitution.

terms of the statute, Ark. Code Ann. § 20-16-1703(d).

R. at 228-29. In addition, there are no factual findings. Though a few facts are recited in the order (which while not disputed, were not stipulated to, as is represented by Respondents in the order R..at 227-28; the remaining facts put in evidence by Petitioners' several affidavits and exhibits, which were not disputed by Respondents, are ignored. R. at 227-28

Respondents imply that the ABH order is sufficient to allow judicial review of the individual issues raised by Petitioners in their appeal to ABH by arguing that *Hanks* is no longer good law and that rulings on individual issues are unnecessary. Resp. at 5. The above analysis of *Hanks* and *Hardin* shows the contrary. To the extent that *Hanks* still applies to appeals from administrative agency decisions, which Petitioners contend is so, Respondents are effectively depriving Petitioners of their right to an appeal of the ABH decision by failing to comply with the APA itself and with *Hanks*. This Court should ensure Petitioners' right of appeal not only in this Court but beyond, if necessary, and the proper way to conclusively do that is to now require a more complete and specific decision from the agency.

Petitioners Are Not Seeking Appellate Review of ABH's Findings via a Writ of Mandamus

Respondents claim that Petitioners are seeking "ordinary appellate review" of the ABH's finding via mandamus. Resp. at 5. This is incorrect. Petitioners want and are entitled to "ordinary appellate review" of the ABH decision and have filed a notice of appeal. R. at 238. However, because they believe that meaningful appellate review will be denied them absent an appropriate order by Respondents, they are seeking via mandamus to protect their right to this "ordinary appellate review."

WHEREFORE, Petitioners request that their petition for a writ of mandamus be granted.

Dated: January 21, 2019

Respectfully submitted:

/s/Bettina E. Brownstein
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Attorney for Plaintiffs

On Behalf of Arkansas Civil Liberties Union Foundation, Inc. for Plaintiff Little Rock Family Planning Services

JS 44 (Rev. 06/17)

CIVIL COVER SHEET 4:19-cv-46-BRW

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
Little Rock Family Panning Services
Planned Parenthood of Arkansas and Eastern Oklahoma dba Planned Parenthood Great Plains

(b) County of Residence of First Listed Plaintiff Pulaski
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Bettina E. Brownstein
904 West Second Street, Suite 2
Little Rock, AR 72201 | 501-920-1764

DEFENDANTS
Arkansas Board of Health

County of Residence of First Listed Defendant Pulaski
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*
Michael A Cantrell
Arkansas Attorney General's Office
323 Center St, Suite 200, Little Rock AR 72201 | 501-682-8162

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*
Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w Disabilities - Employment
- ☐ 446 Amer. w Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☒ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☐ 1 Original Proceeding ☒ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
28 U.S.C. 1331
Brief description of cause:
Constitutional challenge to Arkansas statute

VII. REQUESTED IN COMPLAINT:
☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.
DEMAND $
CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY *(See instructions)*:
JUDGE DOCKET NUMBER

DATE
01/22/2019
SIGNATURE OF ATTORNEY OF RECORD
Michael Cantrell

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE