



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

May 17, 2021

Office of Population Affairs
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: HHS-OS-2021-0010; Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services (RIN 0937-AA11)

The American College of Obstetricians and Gynecologists (ACOG) is pleased to provide comments in response to the notice of proposed rulemaking (NPRM), “Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services,” RIN 0937-AA11, published in the Federal Register on April 15, 2021 by the U.S. Department of Health and Human Services (HHS).

ACOG is the nation’s leading organization of physicians who provide health services unique to women. As the premier national medical specialty society of women’s health physicians, ACOG has more than 60,000 members representing more than 90 percent of all board-certified obstetrician-gynecologists in the United States. ACOG advocates for policies that preserve the patient-physician relationship and ensure access to health care for women throughout their lives, and believes that a full array of clinical services should be available without costly delays or the imposition of cultural, geographic, financial, or legal barriers. Few federal programs are as important to women’s health care access as the Title X program.

ACOG strongly supports HHS’s NPRM revoking the harmful 2019 Title X regulations and reinstating the 2000 regulations with some revisions. Once finalized, the proposed rule would return Title X to its proper focus on “making comprehensive voluntary family planning services readily available to all persons desiring such services.”¹ Furthermore, because of the devastating impact of the 2019 Title X regulations on the program’s provider network and its patients, ACOG supports finalization of the proposed rule as quickly as possible.

I. The importance of restoring previous rules and network

ACOG agrees with HHS’s statement in the NPRM that “the 2019 rule was a solution in search of a problem, a solution whose severe public health consequences caused much greater problems.”² When the 2019 rule was implemented in August 2019, grantees immediately began to withdraw from Title X rather than comply with the rule’s requirements. Overall, as the NPRM notes, the Title X program lost more than 1,000 health centers.³ Those health centers represented approximately one quarter of all Title X-funded sites in 2019.⁴ Nearly two years later, six states continue to have no Title X-funded provider network (Hawaii, Maine, Oregon, Utah, Vermont, and Washington) and an additional six states have a very limited Title X-funded network (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).⁵ The significant damage to the Title X provider network resulted in at least 1.5 million patients losing access to Title X-funded services.⁶ Despite the prior administration’s assertion that the 2019 rule would cause new applicants to apply for Title X funding and result in “more clients being served,”⁷ the Office of Population Affairs has been unable to find new grantees to fill the gaps the 2019

rule created, including in the six states that lost all Title X-funded services, and has served far fewer patients rather than more.⁸

As HHS explains in the NPRM, federal data shows the rapid and devastating impact of the 2019 rule on access to critical family planning and sexual health services. Title X saw 844,083 fewer patients in 2019 compared to 2018 (3.1 million vs. 3.9 million), a dramatic and rapid 21 percent reduction. This decrease meant that providers were able to offer 280,000 fewer cancer screenings, 1.3 million fewer sexually transmitted infection screenings, and 278,000 fewer confidential HIV tests. Additionally, hundreds of thousands of people lost access to contraceptive care due to the rule. The preliminary numbers for 2020, as shared in the NPRM, are even worse—only an estimated 1.5 million people received Title X-supported services in 2020, a loss of 2.5 million people from the network in just two years.⁹ In a 2016 study, six in ten women seeking contraceptive services at a Title X-funded health center reported that to be their only source of medical care in the past year.¹⁰ Thus, this kind of precipitous decline in patients receiving services through the Title X program has concerning implications for broader access to care.

The 2019 rule interfered with the patient-physician relationship, restricted the information available to patients, and hindered the ability of physicians to practice medicine in accordance with their ethical obligations. ACOG’s Code of Professional Ethics for obstetrician-gynecologists unequivocally states that “the patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments.”¹¹ The patient-physician relationship is essential to the provision of safe and quality medical care, and was jeopardized by the 2019 rule by placing restrictions on the ability of physicians to make available important medical information to their patients. Further, ACOG’s Code of Professional Ethics states that obstetrician-gynecologists should “serve as the patient’s advocate and exercise all reasonable means to ensure that appropriate care is provided to the patient.”¹² By restricting the ability of physicians to provide clear, direct information to patients, even going so far as to actively require physicians to withhold full and accurate information and provide referrals to clinicians that do not offer the service requested by the patient, the 2019 rule sought to purposely mislead patients in order to delay their access to abortion care, and placed physicians in ethically compromised positions.

The 2019 rule severely undermined this bedrock public health program that has provided high quality, affordable family planning and sexual health care to millions for 50 years. ACOG strongly supports the revocation of the 2019 rule, and reinstatement of the 2000 regulations with revisions, so that the Title X program can return its focus to its patients and communities.

II. Health equity

ACOG strongly supports the administration’s emphasis on health equity in the NPRM. The statutory requirements that Title X-funded health centers prioritize people with low incomes, and provide care regardless of ability to pay, ensure that the Title X program is well-positioned to advance health equity for the patients it serves. However, the onerous requirements of the 2019 rule diverted attention and resources from this important work and undermined Title X’s mission to provide equitable, affordable, client-centered, quality family planning and sexual health services.

ACOG strongly supports the additions the NPRM makes to the definitions in the Title X regulations, including definitions for health equity and inclusivity. In particular, the transition to using more gender inclusive language is more reflective of the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving care and all people who are capable of becoming pregnant, including queer, transgender, and nonbinary people, should have access to the care they need, including contraception, in an inclusive environment.¹³ The NPRM’s definitions help to illustrate key aspects of quality care including the importance of patient-centeredness; culturally and linguistically

appropriateness; and recognition of how trauma affects people. Defining how services should be provided is an important step towards a more equitable Title X program.

The COVID-19 pandemic has laid bare the many inequities in our nation's health care system and highlighted how systemic racism and other forms of oppression have resulted in pervasive health disparities and disproportionately poor health outcomes for people of color. The Title X program has a significant role to play in combating these systemic barriers to care and ensuring that all people, regardless of their race, ethnicity, age, sexual orientation, gender identity, immigration status, employer, insurance status, or any other demographic, have timely access to comprehensive, high-quality family planning and sexual health services. The NPRM's emphasis on health equity will further support these goals.

Particularly in the wake of CDC's recent declaration that racism is a serious threat to public health, ACOG would like to see systemic racism explicitly included and addressed as part of the expectations related to health equity.¹⁴ Systemic racism and other forms of oppression have resulted in structural barriers to health care services. The Title X family planning program and today's provision of family planning services includes a history of reproductive coercion and injustice experienced by people of color and people with low incomes.¹⁵ This history has contributed to a justifiable mistrust of the health care system, particularly with respect to family planning. As the administration raises health equity as an important goal of Title X in the NPRM, ACOG urges HHS to acknowledge that history as a part of that work.

III. State restrictions on provider networks

ACOG strongly supports ensuring that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients. Despite mounting evidence that expelling well-qualified, trusted family planning providers from publicly funded health programs like Title X has adverse effects on patients' access to critical family planning and sexual health care, states in recent years have increasingly targeted some family planning providers for exclusion from key federal health programs, including Title X. At least 15 states currently have laws on the books that, where funds flow through the state government, could negatively impact the Title X service delivery network. Two additional states have similar bills that are likely to become law this year. Tiering and other prohibitions against family planning providers often exclude the very clinicians that are the most qualified and best equipped to help Title X patients achieve their family planning goals.

The NPRM appropriately recognizes that "state policies restricting eligible subrecipients unnecessarily interfere with beneficiaries' access to the most accessible and qualified providers," and that "denying participation by family planning providers that can provide effective services has resulted in populations in certain geographic areas being left without Title X providers for an extended period of time."¹⁶ ACOG strongly agrees with HHS that "state restrictions on subrecipient eligibility unrelated to the ability to deliver Title X services undermine the mission of the program to ensure widely available access to services by the most qualified providers."¹⁷

The intent of the Title X program is to help individuals—regardless of their economic status, while prioritizing low-income individuals—achieve their family planning goals. Title X funding is therefore provided to public and nonprofit entities to "assist in the establishment and operation of voluntary family planning projects" that offer a broad range of effective family planning methods and services.¹⁸ As noted in the NPRM, "[P]roviders with a reproductive health focus often provide a broader range of contraceptive methods on-site and therefore may reduce additional barriers to accessing services."¹⁹

To best achieve the program’s goals, Title X has historically funded a diverse network of service delivery providers—including state, county, and local health departments, as well as hospitals, family planning councils, Planned Parenthood affiliates, federally qualified health centers, and other private non-profit organizations. These networks vary widely across communities because they are specifically established to provide the most effective care to their specific patient populations. It is therefore imperative that HHS “ensure that Title X projects do not undermine the program’s mission by excluding otherwise qualified providers as subrecipients.”²⁰

IV. Confidentiality

Two interrelated hallmarks of Title X have been the program’s historically strong protections for patient confidentiality and its commitment to serving adolescents. Since the 1970s, federal law has required that both adolescents and adults be able to receive confidential family planning services in Title X projects. Research shows these confidentiality protections are one of the reasons individuals choose to seek care at Title X sites.²¹

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Patients seeking family planning services encompass a broad spectrum of patient populations.²² Certain groups, including adolescents and young adults, and people at risk of intimate partner violence, have special privacy concerns that require particularly strong protection.²³

The 2019 Title X rule weakened these protections by requiring providers to encourage family involvement even when it could be harmful; by giving the HHS Secretary oversight authority in the enforcement of complex and nuanced state reporting laws; and by adding new inappropriate reporting and documentation obligations on providers. In doing so, the 2019 rule undermined the patient-physician relationship to the detriment of public health.

The NPRM would reinstate the Title X confidentiality regulations in place prior to the 2019 rule while making important improvements.²⁴ First, the NPRM eliminates the 2019 rule’s unnecessary and harmful requirements to take and document specific actions to encourage family involvement in the family planning decision making of adolescents, without including the statutory limitation “[t]o the extent practicable”²⁵ and with complete disregard for the expertise, training, and experience Title X providers already use in assisting adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and appropriate.

Second, the NPRM eliminates the 2019 rule’s attempt to give HHS substantial oversight over compliance with complex state reporting requirements concerning child abuse, child molestation, sexual abuse, rape, incest, or human trafficking. Combined with the 2019 rule’s requirements to collect and document specific information in Title X records, as well as that rule’s attempt to give HHS the authority to impose harsh penalties if HHS (not the state) believes a Title X project is out of compliance, the 2019 rule pushed providers toward inappropriate screening and over-reporting that would harm patients and undermine the patient-physician relationship, ultimately resulting in fewer patients seeking critical health services.

Third, the NPRM adds important clarification to how Title X-funded entities are to balance patient confidentiality with the program’s statutory requirement that “no charge will be made for services provided to any clients from a low-income family except to the extent that payment will be made by a third party (including a Government agency) which is authorized to or is under legal obligation to pay this charge.”²⁶

ACOG welcomes the NPRM's addition of language codifying a longstanding practice that had been included in the 2014 Title X Program Requirements that reasonable efforts must be made to "collect charges without jeopardizing client confidentiality," along with a new requirement that patients be informed of "any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client."²⁷ HHS is right to recognize the potential for harm from varied state and local laws regarding the accessibility of patient information to insurance policyholders that are not the patient. As more and more patients have access to insurance, the potential risks of disclosure of sensitive information have increased. These proposed additions to the Title X regulations will help to ensure that confidentiality remains paramount in Title X.

The NPRM proactively addresses the potential within the Title X regulations themselves for harm related to disclosure of a client's sensitive information to third parties such as policyholders who are not the client. In addition, HHS should evaluate Title X's interaction with other laws and regulations for possible conflicts that could undermine Title X patients' confidentiality and potentially subject them to harm.

In addition, ACOG appreciates the amended language of § 59.5(a)(13) to remove the 2019 rule requirement that grant applications and all required reports include referral individuals "by name, location, expertise and services provided or to be provided."²⁸ ACOG's comments on the 2018 proposed rule raised serious concerns with the intent of that requirement to establish, under the auspices of transparency and improved care coordination and without any assurance of confidentiality, an inventory or registry at HHS of the names and locations of clinicians who provide abortion care. However, ACOG does recommend that the agency consider additional alterations § 59.5(a)(13), which the NPRM largely maintains from the 2019 rule, including removal of "individuals providing referral services and the services to be provided."²⁹ It is not standard practice for providers to keep a dedicated and exhaustive list of all of the clinicians they interact with, whether through referral or consultation, nor to keep a comprehensive list of the services provided by those colleagues. The NPRM, consistent with the 2019 rule, would require Title X-funded entities to track services among referral networks that they are not funded to provide, and appears to suggest that Title X-funded entities would be held accountable for outcomes of patients who receive services at other facilities. This is outside the scope and purpose of the Title X program, and holds Title X providers to an unreasonable standard that is inconsistent with other federally-funded programs. Therefore, ACOG recommends limiting the information required to be reported in § 59.5(a)(13) solely to services offered by subrecipients.

V. Standard of care

The Title X program was expressly created in 1970 to make "comprehensive family planning services readily available to all persons desiring such services."³⁰ The statute explicitly requires Title X projects to "offer a broad range of acceptable and effective family planning methods and services," and prioritizes a project's capacity to make rapid and effective use of federal funds for family planning.³¹ The 2019 rule undermined this longstanding standard of care in a variety of ways, including eliminating the term "medically approved" from the longstanding regulatory requirement that projects provide "a broad range of acceptable and effective medically approved family planning methods;"³² overly permissive language that opened the door to participation in the program by providers who object to fundamental tenets of the Title X program; and divergence from the nationally recognized clinical standards, the Quality Family Planning guidelines, published by the Office of Population Affairs and the Centers for Disease Control and Prevention in 2014 (with updates in 2015 and 2017). Furthermore, as mentioned above, the 2019 rule made drastic changes to pregnancy counseling by Title X providers that violated Congress' explicit, repeated mandates; contradicted central principles of medical ethics; and attempted to enlist clinicians in deceiving and delaying patients who seek information about or access to abortion care.

ACOG applauds HHS for the NPRM's return to the core mission of the Title X program, that will once again match patients' expectations that they will receive high-quality patient-centered care that includes comprehensive, medically accurate counseling and information, and referrals for any other services sought. Specifically, ACOG strongly supports the following changes:

- The inclusion of "FDA-approved contraceptive services" and reinstatement of the term "medically approved" to the proposed definition of family planning services;³³
- The requirement that Title X service sites refer patients out if the site does not offer the contraceptive method of the patient's choice;³⁴
- Provide services "in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care;"³⁵
- The reinstatement of the requirement to offer nondirective options counseling to pregnant patients on each of the three options, if requested by the patient, including referral upon request; and³⁶
- The elimination of unnecessary, unworkable physical, systems, and administration separation, contrary to the requirements and realities of modern quality health care.³⁷

VI. Modernizing the Title X regulations is important to the program's future success

Despite the Title X program's success over the course of the program's history, including the nearly two decades spent operating under the 2000 regulations that serve as the basis of this NPRM, changes in the health care delivery landscape necessitate updates to the Title X regulations to account for the context in which services currently are delivered in the family planning safety net.

The NPRM makes an important update in § 59.5(b)(1) in recognition that medical services in many Title X-funded health centers can be and are provided by health care professionals who are not physicians. In fact, the NPRM preamble specifically mentions physician assistants and nurse practitioners as the types of health care professionals that provide consultation in Title X settings. Indeed, nurse practitioners, certified nurse-midwives, and physician assistants accounted for 67 percent of the Title X program's full-time equivalent (FTE) Clinical Services Providers (CSPs) in 2019; physicians and registered nurses with an expanded scope of practice accounted for 24 percent and 9 percent of all CSP FTEs, respectively.

Among enhancements it proposes to the 2000 regulations through the NPRM, HHS also specifically highlights "telemedicine." The importance of telehealth more broadly has been growing in recent years and has become particularly clear in the context of the COVID-19 public health emergency. Since spring 2020, use of telehealth modalities has allowed tens – if not hundreds – of thousands of Title X users to remotely access many Title X services without placing themselves at increased risk for potential COVID-19 exposure. ACOG recommends that the use of telehealth be further embedded in the regulations, with an emphasis on equitable access, and therefore suggests the following amendment:

59.5(b)(1): Provide for medical and other qualifying services related to family planning (including consultation by a health care provider, family planning counseling and education, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, including audio-only modalities, regardless of the patient's or provider's setting, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

Consistent with the NPRM's intent to "correct outdated terminology,"³⁸ ACOG recommends that the regulations replace "preconception" with "pregnancy" each time it appears, including in § 59.2, definition of "Family planning services" and § 59.5(a)(1), list of services required by a family planning project.³⁹ ACOG convened the multidisciplinary, consensus-driven reVITALize Gynecology Data

Element Definitions Initiative in 2014 to facilitate the standardization of definitions and data relevant to gynecologic care. One finding of that initiative is that “Conception is a lay term that has no scientific validity and is not generally used in the medical literature because of its variable definition and connotation.”⁴⁰ ACOG therefore recommends against continued use of the nonscientific term “preconception” in favor of “prepregnancy,” consistent with ACOG’s updated clinical guidance⁴¹ and terminology adopted by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development.⁴²

For 50 years, the Title X family planning program has been a critical underpinning of the public health safety net infrastructure that serves millions of people with low incomes each year. ACOG appreciates the opportunity to comment on the NPRM, “Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services.” If you require additional information about the issues raised in these comments, please contact Rachel Tetlow, Federal Affairs Director, at rtetlow@acog.org.

Sincerely,



Maureen G. Phipps, MD, MPH, FACOG
Chief Executive Officer
American College of Obstetricians and Gynecologists

¹Public Law 91-572 (“The Family Planning Services and Population Research Act of 1970”), section 2(1).

² 86 Fed. Reg. at 19817.

³ 86 Fed. Reg. at 19815.

⁴ Mia Zolna et al., *Estimating the impact of changes in the Title X network on patient capacity*, Guttmacher Inst., 2 (Feb. 5, 2020),

https://www.guttmacher.org/sites/default/files/article_files/estimating_the_impact_of_changes_in_the_title_x_network_on_patient_capacity_2.pdf

⁵ 86 Fed. Reg. at 19815.

⁶ Dawson, Ruth. *Trump Administration’s Domestic Gag Rule Has Slashed the Title X Network’s Capacity by Half*. Guttmacher Institute (Feb. 5, 2020). <https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half#>

⁷ 84 Fed. Reg. at 7723.

⁸ OPA released two competitive FOAs for “areas of high need” on May 29, 2020, intending to provide approximately \$18 million through an estimated 10 grants to provide services in areas left without any Title X-funded services. See Grants Notice, HHS, *PA-FPH-20-001, FY2020 Title X Services Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need* (May 29, 2020), <https://www.grants.gov/web/grants/view-opportunity.html?oppId=323353>; Grants Notice, HHS, *PA-FPH-20-002, FY2020 Title X Service Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need—Maryland Service Area Only* (May 29, 2020), <https://www.grants.gov/web/grants/view-opportunity.html?oppId=327358>. The FOAs yielded only five grantees, four of which were 2019 grantees with current projects and none of which would be providing services in the six states that lost their entire Title X-funded provider network. See Press Release, OPA, *OPA Awards \$8.5 Million in Grants to Family Planning Services in Unserved & Underserved Areas* (Sept. 18, 2020), <https://opa.hhs.gov/about/news/grant-award-announcements/opa-awards-85-million-grants-family-planning-services-unserved>. OPA was able to fund only \$8.6 million in grants under the FOA, with the remaining funding given as supplemental funding to the existing grantees. *Id.*

⁹ 86 Fed. Reg. at 19815.

¹⁰ Kavanaugh, M.L., Zolna, M.R. and Burke, K.L. (2018), Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016. *Perspect Sex Repro H*, 50: 101-109. <https://doi.org/10.1363/psrh.12061>.

¹¹ American College of Obstetricians and Gynecologists. Code of professional ethics of the American College of Obstetricians and Gynecologists . Washington, DC: ACOG; 2018.

¹² Ibid.

¹³ Health care for transgender and gender diverse individuals. ACOG Committee Opinion No. 823. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2021;137:e75–88.

¹⁴ Centers for Disease Control and Prevention. Racism and Health. April 2021. Available at <https://www.cdc.gov/healthequity/racism-disparities/index.html>.

¹⁵ American College of Obstetricians and Gynecologists, et. al. Joint Statement: Collective Action Addressing Racism. August 27, 2020. Available at <https://www.acog.org/news/news-articles/2020/08/joint-statement-obstetrics-and-gynecology-collective-action-addressing-racism>.

¹⁶ 86 Fed. Reg. 19817.

¹⁷ Ibid.

¹⁸ 42 U.S.C. § 300.

¹⁹ 86 Fed. Reg. 19817.

²⁰ Ibid.

²¹ Frost JJ, Gold RB, Bucek A. Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs. *Womens Health Issues*. 2012 Nov-Dec;22(6):e519-25. doi: 10.1016/j.whi.2012.09.002. PMID: 23122212.

²² Rachel B. Gold, *A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents*, 16 GUTTMACHER POLICY REVIEW 2, 2 (2013), <https://www.guttmacher.org/pubs/gpr/16/4/gpr160402.pdf>.

²³ Pamela J. Burke et al., *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491, 491-496, (2014), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Diane M. Reddy, Raymond Fleming, & Carolyne Swain, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 J. AM. MED. ASS'N 710, 710–714 (2002); Rachel K. Jones et al., *Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 J. AM. MED. ASS'N 340, 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, & Laura Lindberg, *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. ADOLESCENT HEALTH 36, 36-43; *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*, Family Violence Prevention Fund (2004), <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf>.

²⁴ Title X's confidentiality requirements are currently largely codified at 42 C.F.R. § 59.11; the NPRM proposes reorganizing the Title X regulations so that the confidentiality section would now be § 59.10.

²⁵ 86 Fed. Reg. 19813.

²⁶ 86 Fed. Reg. 19830.

²⁷ 86 Fed. Reg. 19832.

²⁸ 84 Fed. Reg. 7788.

²⁹ 86 Fed. Reg. 19831.

³⁰ *Planned Parenthood Federation of America, Inc. v. Heckler*, 712 F.2d 650, 651 (D.C. Cir. 1983) (quoting S. REP. No. 91-1004, at 2 (1970)).

³¹ 42 U.S.C. § 300.

³² 84 Fed. Reg. 7740.

³³ 86 Fed. Reg. 19829.

³⁴ 86 Fed. Reg. 19830.

³⁵ Ibid.

³⁶ Ibid.

³⁷ 86 Fed. Reg. 19818.

³⁸ 86 Fed. Reg. 19820.

³⁹ 86 Fed. Reg. 19829-19830.

⁴⁰ American College of Obstetricians and Gynecologists. reVITALize: Gynecology Data Definitions. <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions>.

⁴¹ Prepregnancy counseling. ACOG Committee Opinion No. 762. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2019;133:e78–89.

⁴² Eunice Kennedy Shriver National Institute of Child Health and Human Development. Pre-Pregnancy Care and Prenatal Care. <https://www.nichd.nih.gov/health/topics/preconceptioncare>.