VIA ELECTRONIC TRANSMISSION

September 6, 2024

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (CMS-1809-P)

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Center for Reproductive Rights ("the Center") respectfully submits the following comment on the Notice of Proposed Rulemaking issued by the Centers for Medicare and Medicaid Services ("CMS") and the Department of Health and Human Services to revise the Hospital Outpatient Prospective Payment System ("OPPS") and the Medicare Ambulatory Surgical Center ("ASC") Payment System; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities ("Proposed Rule").[1]

Since 1992, the Center has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 32 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetric care, contraception, safe abortion services, and comprehensive

[1] Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities, 89 Fed. Reg. 59,186 (proposed July 22, 2024) (to be codified at 42 C.F.R. § 406-407, § 410-411, § 416, § 419, § 435, § 440, § 457, § 482, and § 485, and 45 C.F.R. § 480) [hereinafter "Proposed Rule"].

sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where everyone can make these decisions free from coercion or discrimination. As an organization committed to advancing policies that uphold maternal health and rights as fundamental human rights, the primary focus of our comment is the establishment of Health and Safety Guidelines for Obstetrical Services in Hospitals and Critical Access Hospitals, whether those guidelines should be extended to Rural Emergency Hospitals, and the proposal to provide 12 months of continuous eligibility to children under the age of 19 in Medicaid and CHIP. [2]

We deeply appreciate the Administration's efforts to address the maternal health crisis through a whole-of-government approach for advancing health equity and improving birth outcomes. We applaud this effort to create a baseline standard aimed at improving hospital-based labor and delivery care, especially for Black and Indigenous communities who are among those most impacted by the intersecting maternal health and abortion access crises. The Center supports CMS's proposal to implement targeted Obstetrical Services Conditions of Participation ("CoPs") to establish baseline requirements for obstetrical care at hospitals and Critical Access Hospitals ("CAHs"). We would also support future rulemaking that extends these CoPs to Rural Emergency Hospitals ("REHs") that provide pregnancy-related emergency care. We encourage CMS to adopt these guidelines in a way that brings the United States closer to meeting its human rights obligations.[3]

I. The Center supports the proposal put forth by CMS to establish a baseline CoP specific to obstetrical services for hospitals and CAHs.

In the proposed rule, CMS stated that it plans to use its "broad statutory authority to establish health and safety regulations, which includes the authority to establish requirements that protect the health and safety of pregnant, postpartum, and birthing patients."[4] In our response to the Request for Information ("RFI"), published by CMS on May 2, 2024, the Center submitted comments encouraging CMS to adopt these baseline health and safety standards in line with a human rights-based, patient-centered framing. Our recommendations included aligning these baseline standards with evidence-based guidelines put forward by organizations such as the Alliance for Innovation on Maternal Health ("AIM"), American College of Obstetricians and Gynecologists (ACOG), the American Medical Association ("AMA"), and The Joint Commission ("TJC"), among other authorities. Additionally, we encouraged CMS to align these standards with the Availability, Accessibility, Acceptability and Quality ("AAAQ") Framework,[5] in order

[2] *Id* at 59,487.
[3] *See e.g.,* CTR. FOR REPROD. RTS., LAW AND POLICY GUIDE: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY FRAMEWORK https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-availability-accessibility-acceptability-and-quality-framework/ (last visited Jun. 10, 2024); OFFICE OF THE U.N. HIGH COMM'R FOR HUM. RTS., HARVARD FXB CTR. FOR HEALTH AND HUM. RTS., P'SHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH, U.N. POPULATION FUND, AND WHO, SUMMARY REFLECTION GUIDE ON A HUMAN RIGHTS-BASED APPROACH TO HEALTH: APPLICATION TO SEXUAL AND REPRODUCTIVE HEALTH, MATERNAL HEALTH AND UNDER-5 CHILD HEALTH 20 https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/Rguide_HealthPolicyMakers.pdf (last visited Jun. 7, 2024).
[4] Proposed Rule, *supra* note 1, at 59,488.
[5] *See e.g.,* CTR. FOR REPROD. RTS., LAW AND POLICY GUIDE: AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY FRAMEWORK https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-availability-accessibility-acceptability-and-quality-framework/ (last visited Jun. 10, 2024); OFFICE OF THE U.N. HIGH COMM'R FOR HUM. RTS., HARVARD FXB CTR. FOR HEALTH AND HUM. RTS., P'SHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH, U.N. POPULATION FUND, AND WHO, SUMMARY REFLECTION GUIDE ON A HUMAN RIGHTS-BASED

to uphold the dignity, rights, and well-being of birthing individuals, and in line with the United States' human rights obligations. We appreciate CMS for adapting many of the measures, including acknowledging standards set forth by AIM, ACOG, TJC, and the AMA, that we suggested in our response to the RFI, and offer the following additional feedback in response to this proposed rule.

A. *Obstetrical Services CoPs should respect patient autonomy and clearly define requirements around informed consent to procedures and testing, including specific information that makes clear when tests or procedures are mandated or prohibited by the state in line with evidence-based, medically accurate standards of care.*

While CMS does not include specific guidelines or measures around informed consent in the Obstetrical Services CoP, we believe that this falls under the provision of care in line with "nationally recognized acceptable standards of practice for both physical and behavioral… health care of pregnant, birthing, and postpartum people."[6] We encourage CMS to continue to remind hospitals and CAHs of their obligations around informed consent in other CoPs, including the Patient's Rights CoP,[7] the Medical Record Services CoP,[8] and the Surgical Services CoP,[9] and as revised in the April 1, 2024 memo, "Revisions and clarifications to Hospital Interpretive Guidelines for Informed Consent."[10] We also encourage CMS to update each of these CoPs in future rulemaking to align with recommended best practices around informed consent.[11]

B. *Hospitals must ensure timely access to obstetric services, including: emergency and stabilizing care for pregnancy complications in line with the Emergency Medical Treatment and Active Labor Act; a comprehensive range of obstetric services, including prenatal, labor and delivery, postpartum, and neonatal care; and care free from discrimination based on race, ethnicity, nationality, age, sex, gender identity, sexual orientation, disability, religion, or socioeconomic status, in line with federal law.*

Throughout the proposed rule, CMS emphasizes the critical need for timely access to obstetric services, especially in emergency situations. We commend and support CMS for the inclusion of proposals that aim to improve and standardize care to ensure timely delivery of obstetrical services. These proposals include standardizing the preparation of labor and delivery room suites,[12] ensuring the availability of equipment, drugs, blood, biologicals, and other supplies in line with the need of the patient population of each hospital,[13] and a reiteration of hospitals' obligations under the Emergency Medical Treatment and

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APPROACH TO HEALTH: APPLICATION TO SEXUAL AND REPRODUCTIVE HEALTH, MATERNAL HEALTH AND UNDER-5 CHILD HEALTH 20 https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/Rguide_HealthPolicyMakers.pdf (last visited Jun. 7, 2024).

[6] AMA, OPINION 2.1.1: INFORMED CONSENT, CODE OF MEDICAL ETHICS https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (last visited Jun. 10, 2024).

[7] 42 C.F.R. §482.13(b)(2) (1986).

[8] 42 C.F.R. §482.24(c)(4)(v) (1986).

[9] 42 C.F.R. §482.51(b)(2) (1986).

[10] CTRS. FOR MEDICAID & MEDICARE SERVS., CTR. FOR CLINICAL STANDARDS & QUALITY/QUALITY, SAFETY & OVERSIGHT GRP., QSO-24-10-HOSPITALS, REVISIONS AND CLARIFICATIONS TO HOSPITAL INTERPRETIVE GUIDELINES FOR INFORMED CONSENT (2024) *available at* https://www.cms.gov/files/document/qso-24-10-hospitals.pdf.

[11] AMA, *supra* note 6.

[12] Proposed Rule, *supra* note 1, at 59,492.

[13] *Id* at 59,499.

Active Labor Act ("EMTALA") to screen, examine, provide stabilizing treatment to patients experiencing emergencies, or transfer them to another facility under certain circumstances. While CMS does not include discharge planning in this proposed rule, noting that those standards exist in a separate CoP, this proposed rule would require that hospitals have written policies and procedures for transferring patients under their care. The proposal also requires the hospital to provide training to relevant staff regarding policies around transferring patients and encourages all recipient hospitals to have policies and procedures in place regarding the acceptance of transfers. We appreciate that the proposed rule reminds all Medicare-participating hospitals with emergency departments of their obligation to comply with EMTALA and Federal civil rights law.[14] The Center supports these proposals and encourages CMS to include them in the final rule.

C. *Facilities should be prepared to meet the needs of vulnerable populations, including low-income patients, adolescents, and those with pre-existing medical conditions, and should implement cultural competency and implicit bias training for staff at all levels, in line with evidence-based best practices, to ensure respectful and equitable care for all patients.*

In the rule, CMS notes that existing Quality Assessment Performance Improvement ("QAPI") standards do not require that facilities monitor for or address health disparities, or otherwise analyze or stratify QAPI data by patient subpopulations.[15] Despite research showing that meaningful improvements can be made by analyzing data by patient subgroup to identify and address disparities, CMS notes that these data practices have not been universally adopted by hospitals.[16] Therefore, CMS includes a proposal to revise existing QAPI standards for hospitals and CAHs that offer obstetric services by requiring them to assess and improve health outcomes and disparities among obstetric patients on an ongoing basis.

The proposed rule establishes minimum requirements, including that facilities must: "(1) analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the facility among obstetric patients; (2) measure, analyze and track data measures and quality indicators on patient outcomes and disparities in processes of care, services and operations, and outcomes among OB patients; (3) analyze and prioritize patient health outcomes and disparities, develop and implement actions to improve patient health outcomes and disparities, measure results, and track performance to ensure improvements are sustained when disparities exist among OB patients; and (4) conduct at least one performance improvement project focused on improving health outcomes and disparities among the hospital's population(s) of OB patients annually."[17]

This proposal gives hospitals the flexibility to determine the data analysis methodology that best aligns with their patient population, in compliance with HIPAA and without excluding subpopulations with a low number of patients, but still establishes a firm requirement that they conduct this analysis. CMS also notes that the Hospital Inpatient Quality Reporting program and the Health-Related Social Needs screening metrics can be used as additional sources of data hospitals can use to inform their maternal

[14] 45 C.F.R. §92.1-92.6, §92.101-92.105 (2024); 89 Fed. Reg. 37,522- 37,703 (May 6, 2024).
[15] Proposed Rule, *supra* note 1, at 59,495.
[16] THE JOINT COMMISSION, IMPLICIT BIAS IN HEALTH CARE (Apr. 2016) *available at* https://www.jointcommission.org/resources/ news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-23-implicit-bias-in-health-care/implicit-bias-in-health-care/.
[17] Proposed Rule, *supra* note 1, at 59,496.

health QAPI data analysis. The Center strongly commends CMS for this standardization of data collection across hospitals and CAH's and support this proposal.

The proposed rule acknowledges the heighted risk experienced by different populations for severe maternal mortality and morbidity and the need for a new training requirement for hospitals that provide obstetric care. The rule acknowledges disparities in maternal health outcomes for Black, Indigenous, and People of color and the role training can play in improving outcomes. CMS acknowledges that pregnant people with disabilities are more likely to experience severe maternal morbidity or mortality due to complicating factors. The agency notes that providers should receive education on these risks and care management best practices for patients with disabilities in order to ensure they receive high-quality care throughout their pregnancy and after. CMS also acknowledges that those with Limited English Proficiency are more likely to experience disparities in their care or have missed mental health complications during and after pregnancy because of a lack of language-concordant care.

In accordance with these acknowledgements, the proposed rule includes a requirement that hospitals and CAHs with obstetric services develop policies and procedures that ensure staff are trained on select topics to improve the delivery of pregnancy-related care. While the training topics are not prescriptive, CMS requires that they reflect the scope and complexity of services offered at participating facilities, and examples provided include trainings on person-centered care, trauma-informed care, and cultural competency. We appreciate and support this proposal and encourage CMS to share resources that include trainings around implicit bias in health care.

D. *The CoP should require hospitals and CAHs to adhere to the highest standards of quality care and patient safety, evidence-based clinical guidelines, and best practices in obstetrics, which are vital for minimizing risks and optimizing birth outcomes.*

CMS acknowledges the importance of holding all Medicare-participating hospitals to a consistent standard that supports a higher quality of pregnancy-related care. However, proposing a one-size-fits-all standard is not realistic due to differences in facility size, provider practice and expertise, the unique needs of the populations served by each hospital, and because laws vary by state, with some states having already enacted laws and regulations to ensure adequate organizational standards around the delivery of obstetric care. Therefore, the rule proposes that the organization of obstetrical services be appropriate to the scope of services offered by the participating facility and be integrated with other departments, including laboratory, anesthesia, and surgical services as appropriate.[18] The proposed rule establishes a minimum standard of staffing within the obstetric unit that allows for services to be well organized and provided in alignment with nationally recognized standards set by medical professional societies and/or accrediting organizations.[19] Facilities are still required to share those standards with CMS and demonstrate that they are in alignment with nationally recognized, evidence-based sources. The proposed rule allows hospitals the flexibility for alignment with the level and scope of the obstetric services

[18] BLACK MAMAS MATTER ALLIANCE AND CTR. FOR REPROD. RTS., BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE (2018) *available at* http://blackmamasmatter.org/wp-content/uploads/2018/05/ USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf.
[19] Proposed Rule, *supra* note 1, at 59,491.

provided at their facility, but in a way that does not to create a burden on facilities with limited resources, such as those in rural and underserved areas.

The staffing requirements set forth by CMS allow for a broader set of providers to supervise obstetric patient care units, so long as they possess the necessary education and training. This includes registered nurses ("RNs"), certified nurse midwives ("CNMs"), nurse practitioners ("NP's), physicians' assistants ("PAs"), or a Doctor of Medicine ("MD") or Osteopathy ("DO"). This is particularly notable because it expands the universe of providers beyond just physicians, acknowledging that other practitioners are important to the delivery of care, and does not include a requirement that non-physicians be under the supervision of an MD or DO. Allowing RNs, CNMs, NPs, and PAs to supervise labor and delivery would give greater flexibility to the division of labor and the provision of care in obstetric units. This proposed CoP also makes it clear that this list of practitioners who are made available to patients is not exclusive, and that hospitals can credential and grant privileges to a diverse range of providers, as long as it aligns with state laws.

We support this proposal and appreciate that CMS left room for a broader set of stakeholders, such as Certified Professional Midwives, Direct Entry Midwives, Tribal Midwives, doulas, and other community birth workers, to be included in the staffing of labor and delivery units, as state law allows. We hope to see future opportunities to expand the scope of obstetric services to include these stakeholders as a regular part of the delivery of care across the country.

II. Hospitals should establish mechanisms for patients to provide feedback on their care and experiences without fear of retribution, and clear policies must be in place for addressing complaints and incidents of mistreatment or rights violations.

In creating the Obstetric Services CoP, CMS did not create a baseline requirement around hospital surveys to capture patient experiences. As we stated in our response to the RFI, we understand that there are various patient satisfaction reporting mechanisms, including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and Childbirth Experience Survey, both spearheaded by CMS.[20] However, we encourage CMS in future rulemaking to consider a requirement around surveying patient experiences related to the provision of pregnancy-related care. These surveys can be especially critical when it comes to capturing experiences of abuse or disrespect during labor and delivery, which are unlikely to be captured in the raw data analyzed in the QAPI program. Data can then be leveraged to improve decision-making processes and direct resources to better serve the needs of patients.[21] Hospitals can also use survey data when engaging with community-based organizations and community birth workers to better understand and address additional needs and concerns, especially those

[20] Letter from Jeff Micklos, Ex. Dir., Health Care Transformation Task Force, to Caren Ginsberg, Dir., CAHPS and SOPS Program, Ctr. for Quality Improvement and Patient Safety (May 5, 2023) *available at* https://hcttf.org/wp-content/uploads/2023/05/Maternity-Care-CAHPS-RFI_HCTTF-Final-.pdf.

[21] Samia Saeb, et al., *Capacity-Building for Collecting Patient-Reported Outcomes and Experiences (PRO) Data Across Hospitals*, 27 MATERNAL AND CHILD HEALTH J., (2023) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10359358/; NAT'L P'SHIP FOR WOMEN AND FAMILIES, RAISING THE BAR FOR MATERNAL HEALTH EQUITY AND EXCELLENCE: ACTIONABLE STRATEGIES FOR HEALTHCARE SYSTEMS (2023) *available at* https://nationalpartnership.org/wp-content/uploads/2023/04/raisingthebar-report.pdf.

raised by marginalized or vulnerable populations, and work to build networks that can better meet patient needs.[22]

III. The Center supports CMS's proposal for hospitals and CAHs to utilize Maternal Mortality Review Committee data as part of their CoPs.

We support CMS's proposal to require qualifying hospitals and CAHs to have a process for incorporating Maternal Mortality Review Committee ("MMRC") data and recommendations into the facility's QAPI program, in states where MMRCs exist. Active incorporation of feedback from MMRCs, which includes considerations for health disparities, will allow hospitals to demonstrate their commitment to continuous improvement in the provision of pregnancy-related care and improving disparities in maternal health outcomes. This requirement supports the creation of evidence-based policies and practices that can save lives.

IV. The Center supports CMS's proposal to provide continuous eligibility to children in Medicaid and CHIP until age 19.

As CMS indicated in its proposed rule,[23] research demonstrates the numerous benefits to low-income families when children have continuous enrollment in health care.[24] These benefits include continued access to necessary care and medications for chronic health issues and conditions, reduced trips to the emergency room, reduced medical debt for families, and consistency in providers and care for children.[25] Overall, this policy could help reduce disparities in health outcomes for children from low-income families, and reduce stress experienced by parents and birthing people as they try to navigate their own health care access in addition to their children's care. Additionally, ensuring that adolescents and young adults have continuous access to health care can improve their overall health over the course of their life.[26] Access to continuous care will help to ensure that young people receive care for chronic conditions from an early age, reducing their chances for complications later in life. Additionally, ensuring that adolescents and young adults have access to high-quality sexual and reproductive health care, including access to contraceptive counselling, STI and STD counselling, and pregnancy-related care will help set

[22] PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE, USING A NEW SURVEY TO LEARN ABOUT WOMEN'S EXPERIENCES WITH HOSPITAL CARE FOR CHILDBIRTH https://www.pcori.org/research-results/2017/using-new-survey-learn-about-womens-experiences-hospital-care-childbirth (last visited Aug. 10, 2024).
[23] Proposed Rule, *supra* note 1, at 59,487.
[24] *See e.g.,* Cindy Mann and Emma Daugherty, *States Are Adopting New Policies to Help Children Stay Enrolled in Medicaid and CHIP*, THE COMMONWEALTH FUND (Dec. 20, 2023) *available at* https://www.commonwealthfund.org/blog/ 2023/states-are-adopting-new-policies-help-children-stay-enrolled-medicaid-and-chip; Cathy Hope, Medicaid and CHIP Continuous Coverage for Children, GEORGETOWN CTR. FOR CHILDREN AND FAMILIES (Oct. 7, 2022) *available at* https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/; Elizabeth Williams et al., *Implications of Continuous Eligibility Policies for Children's Medicaid Enrollment Churn*, KFF (Dec. 21, 2022) *available at* https://www.kff.org/medicaid/issue-brief/implications-of-continuous-eligibility-policies-for-childrens-medicaid-enrollment-churn/.
[25] Cathy Hope, Medicaid and CHIP Continuous Coverage for Children, GEORGETOWN CTR. FOR CHILDREN AND FAMILIES (Oct. 7, 2022) *available at* https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/; Elizabeth Williams et al., *Implications of Continuous Eligibility Policies for Children's Medicaid Enrollment Churn*, KFF (Dec. 21, 2022) *available at* https://www.kff.org/medicaid/issue-brief/implications-of-continuous-eligibility-policies-for-childrens-medicaid-enrollment-churn/.
[26] AMERICAN ACADEMY OF PEDIATRICS, WE ALL WIN WHEN KIDS ARE COVERED, https://downloads.aap.org/AAP/PDF/AAP-we-all-win-when-kids-are-covered_flyer.pdf (last visited Sep. 6, 2024).

them for better health outcomes as youths and into adulthood.[27] The Center applauds this effort from CMS to support families and ensure children have continuous coverage and consistent care.

V. Conclusion

Thank you for your consideration of our comments. If you require any additional information about the issues raised in this letter, please contact Vandana Ranjan, Senior Federal Policy and Advocacy Adviser, Maternal Health, at the Center for Reproductive Rights at vranjan@reprorights.org.

Sincerely,
Vandana Ranjan

[27] ADVOCATES FOR YOUTH, INDEPENDENT ACCESS TO CONFIDENTIAL HEALTH SERVICES: VITAL FOR YOUNG PEOPLE TO DEVELOP HEALTHY LIVES, https://www.advocatesforyouth.org/resources/policy-advocacy/independent-access-to-confidential-health-services/ (last visited Sep. 6, 2024).