From:	Clauson, Elyssa Sara
To:	EBSA MHPAEA Request for Comments
Cc:	Hoffman, Sarah; Willing, Laura; Kinlow, Tonya
Subject:	Comments on Technical Release 2023-01P
Date:	Tuesday, October 17, 2023 8:04:19 PM
Attachments:	MHPAEA Technical Release Children"s National Comments 10.17.23.pdf

Hello,

Please see attached for Children's National Hospital's comments on the Technical Release 2023-01P.

Thank you,

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Children's National Hospital

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October 17, 2023

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

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20002

The Honorable Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments on Technical Release 2023-01P

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell;

Children's National Hospital (Children's National) appreciates the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act (hereinafter "Technical Release").

As one of the top children's hospitals in the nation, our mission at Children's National is to excel in care, advocacy, research, and education. We accomplish this through providing a quality healthcare experience for our patients and families, improving health outcomes for children regionally, nationally, and internationally, and leading the creation of innovative solutions to pediatric health challenges. Prioritizing diversity and inclusion is essential to achieving our mission.

As a leading provider of pediatric medicine, we are determined to address the wide range of physical, mental, and emotional symptoms that affect our patients' health and wellbeing. At Children's National, our providers treat a wide variety of mental health conditions in outpatient and inpatient settings, as well as in the emergency department. We also are aware that oftentimes the physical health conditions that affect our children come with multiple mental and emotional co-morbidities. COVID-19 exacerbated the youth behavioral health crisis and created many additional barriers for youth to access necessary behavioral health services.[1] Ensuring access, affordability, and parity of mental health care is a high priority for Children's National. Enhancing mental health and effectively addressing mental health conditions helps children reach important development milestones, encourages academic success, and delivers increased emotional wellbeing as they progress through adolescence and adulthood. Children's National Hospital strongly believes that mental health parity should be accessible for all Americans and should apply to all health plans, including Medicare, Medicaid, and all private/commercial plans.

We strongly support the Departments' proposed NQTL data collection requirements relating to network composition as part of the Departments' efforts to increase access to mental health and substance use disorder (MH/SUD) treatment. Such data collection is critical to ensure that plans and issuers do not impose treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical (M/S) treatment. Combined with the accompanying proposed requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA), the data collection requirements that are envisioned in the Technical Release would be powerful steps in the right direction to increasing access to MH/SUD treatment. We urge the Departments to require that the data points for MH services and SUD services be separately collected, analyzed and reported, consistent with MHPAEA statutory and regulatory requirements. Data should also be collected for M/S services to facilitate MHPAEA comparisons. We also urge the Departments to require that all data be collected, analyzed, and reported by age group, including children and adolescents, and by race/ethnicity (where possible). The Departments should also develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across plans/issuers.

We appreciate the Departments' commitment to ensuring that the data plans/issuers will be required to collect are an accurate reflection of individuals' access to treatment. Given that the Departments' guidance to plans will likely need to evolve over time to ensure such accuracy, we urge the Departments not to proceed with a "safe harbor" for plans/issuers based on data collection that has yet to be validated as meaningful. As we describe below, we believe that a "safe harbor" should not be explored until data collection has been extensively validated. Otherwise, the Departments may give "safe

[1] American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, & Children's Hospital Association. (2021, October 19). *AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health* [Press release]. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

harbor" to plans/issuers that impose discriminatory barriers that inhibit access to MH/SUD treatment.

Our full comments are as follows.

Out-of-Network Utilization

Studies indicate that the percentage of services received out of network (OON) is a key indicator of the availability of in-network services. Due to the higher cost-sharing of OON services, individuals rarely choose to obtain care OON if adequate in-network services are available on a timely basis. The landmark Milliman report demonstrates the importance of such data and how frequently MH/SUD care is obtained OON compared to M/S care. The data should be disaggregated by age groups wherever possible, so that utilization by children and adolescents can be distinguished from adults. This is particularly important given that half of lifetime mental health conditions begin by age 14 and our country's ongoing youth mental health emergency.

Children's National supports the Departments' reference to quantitative templates in the Appendix that have already been validated and are in use by employer groups and state regulators. The Bowman Family Foundation Report, which is based on a patient and provider survey conducted by NORC, shows multiple analyses of OON use and access problems, as do other consumer and employer and provider surveys and studies. Recently published research also shows that MH/SUD patients go out of network because of MH/SUD network inadequacies – the same reasons that M/S patients go out of network.

Percentage of In-Network Providers Actively Submitting Claims

Research studies indicate that collecting this data is critically important to determining the adequacy of a network. Plans/issuers frequently pad their networks by having providers listed as in-network even if they aren't actively submitting claims. This metric can also be important in suggesting the existence of other reasons why providers listed as in-network might not be available, including low reimbursement that incentivizes providers to fill appointments with patients with insurance that pays more and/or cash-pay patients. Again, this data should be disaggregated by children and adolescents wherever possible. While we welcome the Departments' reference to child psychiatrists and psychologists, all types of pediatric providers should be included. Additionally, it is important to include data on M/S pediatric subspecialists to the lists (e.g., pediatric cardiologists, pediatric neurologists, etc.) for purposes of assessing parity. We encourage the Departments to require actual participation data on all sub-types of MH/SUD professional providers for both adults and children, as well as inpatient and outpatient facilities.

The harms of inaccurate network directories are often faced by our low-income families trying to get access to various treatments for ASD, such as Applied Behavioral Analysis (ABA), an integral treatment for ASD that had been adopted by the American

Psychological Association and many professional organizations[2]. Members of our ASD services team often face many barriers finding ABA agencies that are in network with our patients' Medicaid insurance. Certain insurance companies have little information about ABA therapy contacts on their website, and our providers also face a substantial challenge in contacting the health carrier's outreach department for a list of resources. If companies do share resources, many of the contacts lead to ghost providers such as providers that are not accepting new patients, facilities that do not provide ABA therapy, and contact numbers that are not in service. Given the difficulty for a care coordinator to easily access resource information for families, it is safe to assume families also will have barriers to accessing therapy resources, which contributes further to inequitable health access and outcomes.

Additionally, inaccurate listings for the required specialty have resulted in lengthy delays of care. For example, one patient found only one in-network therapist who was accepting new patients. Unfortunately, that one therapist had only ever worked with adults and had a treatment lens that was not compatible with the patient's religion. Only after 12 months of attempting to find an in-network therapist could the family finally get a single-case agreement with Children's National.

Time and Distance Standards

Children's National strongly supports the Departments' suggestion that the Departments collect detailed data on the percentage of participants/beneficiaries/enrollees who can access specified provider types in-network within a certain time and distance. We strongly agree with the Departments' view that this data would help with the assessment of a plan/issuer's operational compliance with respect to any NQTLs related to network composition. We also recommend that the Departments collect data on appointment wait times, which are an essential metric to measure network adequacy and the most critical for participants/beneficiaries seeking timely access to care.

The Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program (CMS-2439-P), which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require such independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans. We recommend that any network adequacy standards, such as time/distance, wait times, etc., issued by state or federal governments identify key sub-types of MH/SUD professional providers, such as child and adult psychiatrists, child and adult psychologists, master's level social workers and mental health counselors, psychiatric ARNPs, psychiatric PAs. In addition, all acute and sub-acute inpatient sub-types should have specific network adequacy standards, as well as sub-types of outpatient facility programs, such as IOP, PHP, ABA, MAT, eating disorder, etc.

[2] American Psychological Association. (2017). *APA Policy: Applied Behavior Analysis*. Retrieved from: http://www.apa.org/about/policy/applied-behavior-analysis

In collecting data, the Departments should collect data on routine and crisis appointments, including for follow-up and ongoing care. When only initial appointment wait times are measured, plans/issuers can manipulate their practices to have initial "intake" appointments while having long delays in the delivery of ongoing services. Data should be disaggregated by age group to assess wait times and travel distance for children and adolescents.

Wait times to be seen by a provider are just as important in determining true access to care as time/distance standards. Wait times specifically affect low-income families who are not able to pay out-of-pocket for mental health care. These should be included as standards now, not just collecting data for the future. Additionally, we would like to note that between the time to intake appointment and the time to initiation of intervention (medication or therapy) often have very separate processes and waitlists and should be categorized separately in data collection.

Network Availability and Distribution of Professions

Children's National applauds the Departments for focusing on whether providers are accepting new patients (Section (iv)(2)), which is a crucial issue in light of the high demand for MH/SUD services. A MH/SUD provider with just a few time slots available does not add significant capacity to plans/issuers' networks. We believe that the Departments should require that any network adequacy standard should consider typical limits on MH/SUD providers, who typically have smaller caseloads, less capacity and limited availability for new patients as compared to most M/S professional providers. (For example, a standard that equates 1 full-time PCP to 1 full-time Psychologist is not comparable in light of the differences in caseloads and capacity). It is also important to require metrics on the number of available providers who fill high demand needs in the network, such as those seeing children & adolescents, those who specialize in eating disorders or LGBTQ patients, and those who meet the language needs of the population served by the network. While the Service Utilization metrics below in these same categories would address how much certain services are being utilized, it may be that while there is a reasonable level of, for example, eating disorder services provided by network providers, those providers may be completely full. Thus, it is also important to assess whether new patients with these specialized needs can find available providers.

A robust network has a full range of different professions and training levels to handle the varying needs and more complex problems of the patient population. Thus, we recommend gathering data (on both the MH/SUD and M/S sides) on the percentage of the top 10 different professions that make up the network. We also support that plans should measure the actual numbers of licensed MH/SUD professionals by geo zip code. Telehealth can supplement the network, but it should not be in lieu of an in-person network. Children's National feels strongly that there should NOT be a telehealth-only separate network.

A strong network with appropriate network composition would include a broad range of mental health providers. Our patients need affordable and accessible providers that

cover a range of specialties, from preschool age behavioral difficulties to episodes of psychosis among adolescents. Specifically, Children's National Hospital has the following specialty psychology and psychiatry clinics: ADHD & Learning Differences Program, Anxiety Disorders Program, Child Development Program, Early Childhood Behavioral Health Program, HIV Services Mental Health Program, Hyperactivity, Attention, and Learning Problems (HALP) Clinic, Center for Autism Spectrum Disorders, and the Mood Disorders Program. Additionally, our psychologists are embedded in and serve as consultants to many divisions and programs throughout Children's including Allergy and Immunology, Bariatric Surgery, Cardiology, Craniofacial Program, Diabetes and Endocrinology, Epilepsy, Gastroenterology, Hematology, Kidney Transplantation, Neonatology, Oncology, Pain Medicine Care Complex, Pulmonary Medicine, Sleep Medicine, Trauma and Burn Surgery and Primary Care.

Each of these specialties requires unique and tailored knowledge, and each should be accessible for children who need them.

With eating disorders, many patients need access to several specialty clinics and services, each just as important as the other. Providers at Children's National Hospital have shared that the network adequacy failures in mental health care result in significant major equity issues. Specifically, in the District of Columbia, many insurance plans do not have an in-network intensive inpatient eating disorder treatment facility. and there are few outpatient providers that are fully trained and equipped to handle the complexities of severe eating disorders. Because of this, children and adolescents with these plans may fail to receive the help they truly need to address the mental health components of their eating disorder, ultimately increasing their risk for recurring hospitalizations and even fatality. Children's National Hospital has seen an upsurge in emergency room visits for eating disorders since the onslaught of COVID-19. One provider emphasized the stark equity issues and lack of adequate provider networks to treat the mental health components of eating disorders.

Network adequacy and behavioral health care infrastructure issues have often made it difficult for providers to collaborate on the mental and physical components of eating disorders. A patient with many co-occurring psychological and medical complexities was not able to continue seeking psychological treatment for disordered eating when their insurance switched to a different insurance carrier that carved out behavioral health care, a clear violation of parity, since their new insurance will cover physical health treatments for the same ailments, but the behavioral health insurer will not cover necessary behavioral health treatments provided in the same facility. This patient has since failed to receive mental health care elsewhere because of network adequacy and quality issues.

Network Admissions

In assessing network composition and access to MH/SUD services, Children's National urges the Departments to review the criteria and processes by which plans/issuers determine which providers to admit into networks and/or how plans/issuers define when a network is considered "full" or "closed." Reports from MH/SUD providers suggest that

they are often denied participation on networks due to the networks being “closed” or “full,” even though patients are unable to find appropriate providers in that network. Other providers who are eventually admitted into networks report having to wait as long as nine months to be added.

Plans/issuers should not be allowed to claim a workforce shortage as a reason for access to care issues and simultaneously keep networks locked or slow to accept new providers. Measuring and monitoring access to care for all sub-types of MH/SUD providers will reveal how much responsibility plans/issuers bear for the lack of access to MH/SUD services. For example, plans/issuers should provide metrics on how many providers applied to the network, what percentage were rejected and the reasons for the rejection (e.g., network full, provider not qualified, and the time it takes to bring providers into the network from when they first apply).

Reimbursement Rates

Children’s National applauds the Departments’ suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy; many studies show the strong correlation between network access and reimbursement rates. We also commend the Departments for putting forward potential requirements that reimbursement rate data be “compared to billed rates.” Reimbursement rates that are not reflective of current market reimbursement can profoundly affect the availability of MH/SUD providers, including current providers’ decision to join a network and potential providers’ decisions whether to enter the field. We strongly recommend the Departments evaluate the ratio of allowed in-network and OON amounts to OON billed market rates for MH/SUD and M/S. The billed rates of OON providers are the most accurate representation of the market rate. We also support developing additional reimbursement rate measures, such as percent of out-of-pocket (OOP) expenses for enrollees using out-of-network providers for MH/SUD versus M/S care.

With respect to the use of Medicare Fee Schedule and other external benchmarks such as Fair Health, we urge the Departments to utilize significant care to avoid perpetuating historic (and ongoing) disparities between MH/SUD and M/S reimbursement rates that are embedded in these benchmarks. We urge the Departments to recognize that Medicare and other claims databases and benchmarks rely on historical data that embeds legacy disparities in reimbursements between MH/SUD and M/S. Additionally, we strongly believe that caution is warranted with respect to Medicare because it:

- Is not subject to MHPAEA;
- Does not have allowed amounts for certain sub-types of MH/SUD providers (e.g., sub-acute inpatient care and the full range of MH/SUD professional providers);
- Does not cover some MH/SUD services for children and adolescents given that this population does not participate in the program; and
- Has a structure that undervalues the work of MH/SUD professionals, which CMS recently acknowledged in its recent Physician Fee Schedule proposed rules.

Nonetheless, we recognize that the Departments, multiple state regulators, and research organizations (such as Milliman) have documented significant disparities between Medicare allowed amounts and plans/issuers' allowed amounts for MH/SUD providers versus M/S providers. As described below, the ultimate determiner of parity for any reimbursement comparison is the access to services (i.e., adequacy) within MH/SUD networks in comparison with M/S networks. Indeed, reimbursement rate comparisons could actually show that MH/SUD providers are reimbursed at the same level as M/S providers, yet if MH/SUD network inadequacies persist, plans/issuers should be required to increase rates further for MH/SUD providers to address network inadequacies, as plans/issuers do for M/S.

While considering that the Medicare fee schedule and other external benchmarks may have legacy disparities embedded for MH/SUD services compared to M/S services, we have seen that they can be used as tools to demonstrate parity non-compliant reimbursement rates. This was the case in the U.S. Department of Labor and New York Attorney General's 2021 lawsuit against United Healthcare and United Behavioral Health (UBH) and resulting settlement agreement, which were based, in part, on UBH's disparate reductions from baseline rates derived from Medicare.
The Departments have made it clear that when faced with M/S provider shortages, if plans increase reimbursement rates for M/S providers to ensure adequate M/S networks, they must increase rates to address MH/SUD providers shortages as well to ensure adequate behavioral networks. The Bowman Family Foundation publication, "Federal Parity Law (MHPAEA): NQTL of In-Network Reimbursement Rates: Non-Comparable Use of Factors of Provider Leverage a/k/a Bargaining Power and Workforce Shortages" references federal data that shows there are more zip codes in the U.S. with Primary Care Physician (PCP) shortages than Psychiatrist shortages. Yet, there is relatively low out-of-network use for PCPs, and PCPs are routinely paid more than Psychiatrists for the same evaluation and management billing codes. Key quotes include:

> "Nationally, the average in-network reimbursement for MH/SUD professional office visits from commercial insurers was approximately 2.5% below Medicare reimbursement, and OON use of such visits was approximately 17%, i.e., 5.4 times higher than for primary care providers."
>
> "Nationally, the average in-network reimbursement for primary care professional office visits from commercial insurers was approximately 20% above Medicare reimbursement, and OON use of such visits was approximately 3%."
>
> "HRSA identifies "Health Provider Shortage Area" (HPSA) designations, which indicate that demand far exceeds supply. As reported by Kaiser Family Foundation, this national data as of Sept. 30, 2021 shows more shortages for PCPs than for mental health providers (7447 vs. 5930 shortage areas)."

The Departments guidance in the 2020 Self Compliance Tool is also clear:

> "NOTE – Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by

> adjusting provider admission standards, **through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy.** To comply with MHPAEA, plans and issuers must take **measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers,** even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network…" (Emphasis added).

As with all quantitative data metrics, multiple measures are important to accurately assess the compliance of any NQTL. Consistent with the current regulations and enforcement, as well as the Proposed Rules, reimbursement rates for MH/SUD providers are a key aspect of in-network access to care. We have seen that plans/issuers use reimbursement rate increases to establish and maintain adequate M/S networks, especially in addressing shortages of M/S providers. MHPAEA requires plans to take the same measures for MH/SUD providers to ensure adequate networks.

Many of our patients experience very low network adequacy for psychology and psychiatry services. While sometimes providers are unable to accept these plans due to unsustainably low reimbursement rates for mental health, other times providers are denied network coverage despite their willingness to accept it. This concept is extremely rare for physical health benefits, and thus leads to a parity violation. Children's National is passionate that insurance companies need to cover the cost of care. Failure to reimburse at cost, and/or only offering below cost payment, negatively impacts access to care by decreasing the number of mental health providers in network. And this shortage of access most often affects low-income families who are not able to pay out of pocket.

Additionally, the technical release includes "Allowed amounts for CPT codes 99213 and 99214 as well as CPT codes 90834 and 90837 for specific types of MH/SUD and M/S providers." It is appropriate that both E&M codes and therapy codes are included. However, these are just four of the many codes that mental health providers will bill in the course of providing a variety of services. We suggest further research into all of the codes that should be included. Some others to consider include 99215, 90791, 90792, 90875, 90832, 90833, 90839, 90840, 90846, 90847, 90849, 90853, 99245, 99244, and 99243.

Aggregate Data Collection

Children's National strongly supports the Departments, when reviewing self-funded employer group plans, to require relevant data to be collected and evaluated for both employer group enrollees as well as enrollees of the employer's third-party administrator (TPA) or other service provider in the aggregate. We agree with the Department that individual employer group plans may lack sufficient data.

Service Utilization Data

In assessing network composition and access to MH/SUD services, Children's National urges the Departments to require plans to report on utilization rates for specific MH/SUD services and level of care. These utilization rates should be compared to estimates of participants/beneficiaries with these conditions, as well as utilization rates for M/S services. Examples of services providers, settings, and levels of care on which we urge the Departments to collect utilization data include:

- Child and adult psychiatrists, child and adult psychologists, master's level social workers and mental health counselors, psychiatric ARNPs, psychiatric PAs, all acute and sub-acute inpatient sub-types, and sub-types of outpatient facility programs, such as IOP, PHP, ABA, MAT, eating disorders, etc.;
- Each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria and the age-specific Level of Care Utilization System (LOCUS) family of criteria developed by the American Association of Community Psychiatrists and the Academy of Child and Adolescent Psychiatry, as well as the average length of stay / treatment units and denial rates by each of these levels of care;
- Service utilization by MH/SUD diagnoses;
- High demand needs such as services for children and adolescents, eating disorder, and services by providers who meet the language needs of the population served by the network;
- Cognitive behavioral therapy;
- Dialectical behavioral therapy;
- Coordinated Specialty Care;
- Medications for opioid use disorder (MOUD);
- Medications for alcohol use disorder (MAUD); and
- Medications for bipolar disorder, schizophrenia, major depressive disorder, and other MH/SUDs.

Safe Harbor

The Technical Release also requested feedback on the potential of a "safe harbor" for NQTLs related to network composition. Children's National urges the Department not to proceed with a safe harbor at this time. We understand the desire to most effectively target the Departments' enforcement resources. However, network adequacy has always been difficult to define and easy to mismeasure. Even when plans have been provided with templates by various state regulators, data is often incomplete, inconsistent and/or contradictory. Thus, a safe harbor has the potential to be harmful if the data collection requirements do not capture a full and complete picture of participants/beneficiaries' access to MH/SUD services. Given the significant work that the Departments need to do – and likely refinements that are necessary over time – to ensure collected data is complete, accurate, and meaningful, a safe harbor should not be considered in the near future. Such a safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected

accurately captures actual access to MH/SUD services. Data templates should be validated for operational feasibility and accuracy. If a safe harbor is put in place prior to this occurring, it could cause enormous damage by giving noncompliant plans/issuers a "safe harbor" against accountability. Furthermore, an issuer residing within such a "safe harbor" would almost certainly escape meaningful oversight from any applicable State authority.

Meaningful Data & Preventing Data Manipulation

To ensure that the proposed requirements relating to outcomes data and actions to address material differences in access are meaningful, Children's National urges the Departments to issue standardized definitions on all data points and on methods for gathering and reporting data. For example, the Departments propose collecting data on the number and percentage of claims denials. Yet, there are many ways that plans can collect, and potentially manipulate, such "claims denials" data. For example, the Departments should make clear that failure to pay a claim in part or in full constitutes a denial and must find ways to capture common practices of undocumented denials that occur verbally through peer-to-peer reviews. Additionally, plans can manipulate denial data by approving each visit or day of treatment (thereby increasing the denominator) while telling the provider verbally that further visits/days will not be approved, which is another common occurrence. Such practices can result in meaningless data that bears little resemblance to what individual patients experience. The Appendix to the Technical Release lists templates already in use, including the Bowman Family Foundation's Model Data Request Form, which includes a section on Denial Rates. We support the continued use of templates that address the issues set forth above.

Disaggregating MH and SUD Data

Children's National also encourages the Departments to make clear that MH and SUD data must be collected and analyzed separately. When MH and SUD data is simply aggregated, it can hide important discriminatory impacts.

Conclusion

We have included numerous citations to support research, including direct links to the research. We direct the Departments to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If the Departments are not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Tonya Vidal Kinlow at Children's National Hospital, tkinlow@childrensnational.org

Sincerely,

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