OBRA '89 PL 101-239

cient time for a mother to make the transition from welfare to a job that offers health insurance coverage for her and her children.

To further encourage welfare families to work, the Committee bill would allow the States, at their option, to extend the current 12-month transitional coverage period for an additional 12 months (or 3, 6, or 9 months, as the State elects). Thus, a State could offer a working welfare family a total of 24 months of transitional Medicaid coverage (12 mandatory, 12 optional). Under the bill, the structure of the current mandatory benefit would remain unchanged. Thus, States could, at their option, impose the same income-related premium during this optional 12-month period that they are allowed to impose during the 2nd mandatory 6-month period. The Committee bill would also repeal the sunset.

The Committee bill would also make some technical corrections to current law. It clarifies that Medicaid transition coverage terminates at the close of the first month in which the family ceases to include a child, whether or not the child is a dependent child under part A of Title IV, or would be if needy. The Committee bill also clarifies that families who, prior to April 1, 1990, are receiving Medicaid extension coverage under the current law 9-month provision are entitled to continue receiving this extension coverage after that date until their 9-month coverage period expires.

Section 4213—Early and periodic screening, diagnostic, and treatment services

(a) In general.—Under current law, States are required to offer early and periodic screening, diagnostic, and treatment (EPSDT) services to children under age 21. States are required to inform all Medicaid-eligible children of the availability of EPSDT services, to provide (or arrange for the provision of) screening services in all cases when they are requested, and, to arrange for (directly or through referral to appropriate agencies or providers) corrective treatment for which the child health screening indicates a need.

The EPSDT benefit is, in effect, the nation's largest preventive health program for children. Each State must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by the screening. These services are available to children under EPSDT even if they are not available to other Medicaid beneficiaries under the State's plan.

The EPSDT benefit is not currently defined in statute. In the view of the Committee, as Medicaid coverage of poor children expands, both under current law and under the Committee bill, the EPSDT benefit will become even more important to the health status of children in this country. The Committee bill would therefore define the EPSDT benefit in statute to include four distinct elements: (1) screening services, (2) vision services, (3) dental services, and (4) hearing services. Each of these service elements would have its own periodicity schedule that meets reasonable practice standards. These items and services must be covered for children

even if, under the State Medicaid plan, they are not offered to other groups of program beneficiaries.

Under the Committee bill, screening services must, at a minimum, include (1) a comprehensive health and developmental history (including assessment of both physical and mental health development), (2) a comprehensive unclothed physical exam, (3) appropriate immunizations according to age and health history, (4) laboratory tests (including blood lead level assessment appropriate for age and risk factors), and (5) health education (including anticipatory guidance). The Committee emphasizes that anticipatory guidance to the child (or the child's parent or guardian) is a mandatory element of any adequate EPSDT assessment. Anticipatory guidance includes health education and counselling to both parents and children.

Under the Committee bill, vision services must, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Dental services must, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. Hearing services must, at a minimum, include diagnosis and treatment for defects in hearing, including the provision of hearing aids. While States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit. For example, States may not limit dental care to emergency services only, *Mitchell* v. *Johnston*, 701 F. 2d 337 (5th Cir. 1983).

The Committee bill also clarifies the periodic nature of EPSDT services. With respect to screening services, the bill requires that they be provided at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. The Committee intends that these health examinations be provided at intervals that are no greater than those described for well-child care in the "Guidelines for Health Supervision" (1981) of the American Academy of Pediatrics. The Committee is informed that some States use periodicity schedules for medical examinations to govern the frequency with which children may receive dental examinations. The Committee intends that, among older children, dental examinations occur with greater frequency than is the case with physical examinations.

The Committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. The Committee emphasizes that the determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with a child outside of the

health care system (e.g., State early intervention or special education programs, Head Start and day care programs, WIC and other nutritional assistance programs). As long as the child is referred to an EPSDT provider, the child would be entitled to an interperiodic health assessment (or dental, vision, or hearing assessment) or treatment services covered under the State plan.

These same considerations apply with respect to vision, dental, and hearing services, all of which must be provided when indicated as medically necessary to determine the existence of suspected illnesses or conditions. For example, assume that a child is screened at age 5 according to a State's periodicity schedule and is found to have no abnormalities. At age six, the child is referred to the school nurse by a teacher who suspects the child of having a vision problem. Under the Committee bill, the child can—and should—be referred at that point to a qualified provider of vision care for full diagnostic and treatment services, and the State must make payment for those services, even though the next regular vision exam under the State's periodicity schedule does not occur until age 7.

While States may, at their option, impose prior authorization requirements on treatment services, the Committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.

The Committee notes that Medicaid-eligible children are entitled to EPSDT benefits even if they are enrolled in a health maintenance organization, prepaid health plan, or other managed care provider. The Committee expects that States will not contract with a managed care provider unless the provider demonstrates that it has the capacity (whether through its own employees or by contract) to deliver the full array of items and services contained in the EPSDT benefit. The Committee further expects that, in setting payment rates for managed care providers, the States will make available the resources necessary to conduct the required periodic and interperiodic screenings and to provide the required diagnostic and screening services.

The Committee bill clarifies that States are without authority to restrict the classes of qualified providers that may participate in the EPSDT program. Providers that meet the professional qualifications required under State law to provide an EPSDT screening, diagnostic, or treatment service must be permitted to participate in the program even if they deliver services in school settings, and even if they are qualified to deliver only one of the items or services in the EPSDT benefit.

(b) Report on the provision of EPSDT.—In order to assess the effectiveness of State EPSDT programs in reaching eligible children, the Committee bill would require the States to report annually to the Secretary, in a uniform form and manner established by the Secretary, the following information, broken down by age group and by basis of eligibility for Medicaid: (1) the number of children receiving child health screening services; (2) the number of children referred for corrective treatment (the need for which is disclosed by the screening); and (3) the number of children receiving dental services. These reports would be due April 1 of each year (beginning with April 1, 1991) and would apply to services provided

during the Federal fiscal year ending the previous September 30 (beginning with FY 1990).

Section 4214—Extension of payment provisions for medically necessary services in disproportionate share hospitals

(a) Coverage of medically necessary services for children.—Under current law, States may impose reasonable limits on the amount, duration, and scope of covered services. However, effective July 1, 1989, States are prohibited from imposing any fixed durational limit on Medicaid coverage of medically necessary inpatient hospital services provided to infants under age 1 by disproportionate share hospitals. As of January, 1989, according to the National Association of Childrens' Hospitals and Related Institutions, 12 States imposed durational limits on inpatient hospital services for children (Alabama, Alaska, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Missouri, Oregon, Tennessee, Texas, and West Virginia).

The purpose of the current law exception to fixed durational limits is to prohibit States from using arbitrary length of stay limitations (e.g., 20 days per year) to reduce payments for medically necessary services provided by hospitals, including many public and childrens' hospitals, that serve a disproportionate number of low-income patients. The Committee bill would extend this current law prohibition to any fixed durational limits on payment for inpatient services provided to children under age 18 by disproportionate share hospitals. The requirement is effective for inpatient hospital services furnished on or after July 1, 1990.

(b) Assuring adequate payment for inpatient hospital services for children in disproportionate share hospitals.—Under current law, States may reimburse hospitals for inpatient services on a prospective basis. If they choose to do so, States must, effective July 1, 1989, provide for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals involving exceptionally high costs or exceptionally long lengths of stay for infants under 1 year of age. According to the National Association of Children's Hospitals and Related Institutions, as of January, 1989, a total of 44 States pay for inpatient hospital services on a prospective basis; only 17 of these do not make outlier adjustments for high cost or long-stay cases (Alabama, Alaska, California, Colorado, Connecticut, D.C., Florida, Kentucky, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, and Washington).

The Committee bill would extend this current law requirement to cases involving children from age 1 up to age 18. States that pay for inpatient hospital services on a prospective basis would be required to submit to the Secretary, no later than April 1, 1990, a State plan amendment that provides for an outlier adjustment in payment amounts for medically necessary inpatient services provided by disproportionate share hospitals after July 1, 1990, involving exceptionally high costs or exceptionally long lengths of stay for children age 1 up to age 18.