

American Academy of Pediatrics

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June 8, 2015

Andrew M. Slavitt

Acting Administrator

Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services

7500 Security Boulevard

Baltimore, MD 21244

Docket No. CMS-2333-P

Dear Administrator Slavitt:

On behalf of the American Academy of Pediatrics (AAP), an organization of 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I write to offer comments on the proposed rule, "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans."

Nearly 1 in 5 children in the U.S. suffers from a diagnosable mental disorder, but only 20 to 25 percent of affected children receive treatment. There are countless more children who face mental and behavioral impairments that do not meet the criteria for a diagnosis whose needs are not being met by the current system. Despite large and coordinated efforts to include substance use screening and brief intervention as part of general medical care for teens, only 10 percent of teens with substance use disorders enter treatment.

The AAP's comments address four important concerns: access to a medical home, mental health carve-outs, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and long-term services.

Access to a medical home

Families and children need access to mental health/substance use disorder (MH/SUD) screening and assessment and a full array of evidence-based therapeutic services to appropriately address mental health and substance use disorders. The identification, initial assessment, and care of mental health problems should take place in a child's medical home. The medical home is an approach to providing comprehensive primary care in which a care team works in partnership with a child and child's family to assure that all the medical and non-medical needs of the patient are met and that care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and adolescents, including children and adolescents with special health care needs.

The primary care setting provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management. It is a comfortable, familiar setting for families and one that is fully coordinated with the child's other health care. **Children should have access to this range of services, whether a child's condition involves mental health, substance use, physical health, or some combination. Inequitable payment of pediatric primary care providers (PPCPs) for their MH/SUD services results in significant barriers for children with these conditions, as described below.**

Mental health carve-outs

Impact on Pediatricians

PPCPs are frequently not appropriately paid for their time spent in the care of children's mental health problems, in large part, because of mental health carve-outs—separate panels of MH/SUD providers credentialed by an insurance plan to provide MH/SUD services. In many states, mental health services have been carved out, whereby the Medicaid and CHIP managed care organization pays only the contracted mental health specialists on its mental health panel for these services. These plans typically do not credential pediatricians to provide care on the mental health panel and, thus, pediatricians are considered ineligible to bill for the mental health services they provide in their office. In these instances, the utilization of a mental health carve-out poses a significant barrier to access for mental health care for many children. When pediatricians are excluded from mental health care, including early identification, children's mental health conditions may become quite severe before they are identified and begin treatment. The current shortage of child psychiatrists, developmental/behavioral pediatric subspecialists, and child psychologists compounds this inequity.

As a result, the pediatric workforce available to provide at least some mental health and substance abuse services are denied payment and are not adequately integrated into existing mental health networks, which consistently impedes timely access to needed care for children and their families. Only through clear guidance by CMS will this lack of parity be corrected. We recommend that state Medicaid and CHIP contracted plans and providers include pediatric providers in their network of mental health providers, including those using carve-out arrangements. We also urge CMS to direct states to allow pediatric providers to bill for mental health services as they do physical services and not to impose arbitrary restrictions based on their provider type. We believe these two recommendations will have a significant impact on expanding access to timely and high quality screening, counseling, and other mental health services for children, including needed referrals to mental health and substance abuse services.

We applaud CMS for publishing this proposed rule and believe that mental health parity has the potential to improve access to mental health and substance use disorder treatment for children and adolescents. By adopting the approach that gives states flexibility to maintain existing delivery systems while demonstrating compliance with MHPAEA requirements, CMS has missed an important opportunity to deal with the structural barriers to true parity that have persisted since carve-outs have been employed. **The proposed rule fails to account for the role mental health carve-outs have played in widening the gap between medical/surgical health**

care and MH/SUD for children and adolescents. The AAP is deeply concerned about the effect the proposed rule would have on exacerbating the use of carve-outs. This comes at a time when many professional organizations, including the AAP, have advocated for policies and systems changes that integrate mental health into pediatric primary care settings.

Illustrative example

Here is an illustrative example from a state with Medicaid fee-for-service (FFS) where the mental health services are carved out through the use of a mental health managed care organization (MCO):

The pediatric primary care provider (PPCP) elicits issues from the family and feels a referral to behavioral health services is needed. The PPCP cannot refer to the MCO directly. The family must call the intake phone number and repeat the entire intake process. Then the disposition of the case will be decided based on the intake information. The family will be referred to someone on the MCO panel. The PPCP has no input, the mental health provider is unknown to the PPCP, and there is no way to know whether the mental health provider offers the therapy that is indicated. It will be up to the family to try to assure that the mental health provider communicates with the PPCP.

In state Medicaid and CHIP programs that have transitioned from FFS to a mental health MCO, even if the PPCP had a referral relationship with a community mental health provider in the FFS system where they could get feedback and co-manage a child's medical and mental health care, the use of the MCO or multiple MCOs in a geographic area has limited their panels directly or indirectly through cumbersome processes and paperwork or slow billing, leaving many mental health providers unable to continue serving children in Medicaid or CHIP. That same mental health provider, who may have been co-located with a PPCP, has to stop seeing children on Medicaid and CHIP.

Impact on children and adolescents

Mental health carve-outs stigmatize mental health by treating conditions affecting the brain as separate and different from conditions affecting the rest of the body. Mental health intake procedures that bypass the primary care clinician, without requirements for communication between mental health providers and PPCPs, without care coordination mechanisms, and, too often, without pediatric expertise among mental health providers, impede PPCPs delivery of mental health services in the medical home. Because Medicaid mental health MCOs are designed to manage benefits for individuals with severe and persistent mental illness, they may not be adequately staffed to manage the large number of children with emerging mental health concerns or those with a mental health condition that has not met state-specific diagnostic or functional criteria to qualify as a serious emotional disturbance.

Opportunities for the final rule

At a minimum, the final rule should set explicit criteria for how the use of a mental health carve-out would violate the parity requirement, especially through the use of nonquantitative treatment limitations (NQTL). The proposed rule allows states to maintain existing, oftentimes complicated delivery systems and then instructs states to undertake a parity analysis across these systems. Much more guidance to states will be necessary to ensure appropriate enforcement of the MHPAEA requirements as they pertain to children and adolescents. If wrap-around services are provided by the state, consideration should be given as to how to apply the parity test to those services, including network adequacy and billing for those services. For children and adolescents, a full array of evidence-based therapeutic MH/SUD services should be required as part of any state contract with an MCO. In the final rule, we recommend CMS provide examples for states of screening tools for very young children in the description of generally recognized independent standards of current medical practice such as the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3R), a diagnostic classification for mental health symptoms and disorders in infants, toddlers, and preschoolers. The AAP would be pleased to work with CMS to identify specific examples of screening tools for children and adolescents.

CMS should also set much more stringent requirements for how the carve-out operates and what processes and procedures should be in place to coordinate and integrate care with the pediatric primary care provider. Upon issuance of a final rule, additional guidance to states, pediatric primary care providers, and families are needed so that they are better able to identify when a violation of parity has occurred.

The proposed rule provides an illustrative list of NQTLs that includes network tied design, standards for provider admission to participate in a network, including reimbursement rates and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits or services provided under the plan or coverage. As CMS finalizes the rule, we encourage you to look more closely at states with mental health carve-outs for children in Medicaid and CHIP and provide specific examples of how Medicaid and CHIP mental health carve-outs meet these standards and examples of how they do not. Based on the experience of pediatricians in states with these arrangements, no other medical or surgical service experiences the barriers to access that carve outs have created for children and adolescents needing MH/SUD treatment.

Additionally, we would note that the proposed rule cites reimbursement rates as a form of NQTL. Payments rates in Medicaid continue to be a barrier to access to mental health and certain mental and behavioral health services for children and adolescents are not reimbursed at all. We would ask that CMS look at the disparities in Medicaid payment rates, monitor the rates paid for mental health and substance use disorder services for potential violations of parity requirements, and take enforcement action with states or managed care organizations where necessary.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The AAP recommends that all state Medicaid agencies provide all children at a minimum the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and all other mandatory and optional benefits as outlined in the accompanying AAP statement, “Scope of Health Care Benefits for Children From Birth Through Age 26.”ⁱ Furthermore, each state’s process for determining medical necessity should rely on the expertise of pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. In the process of making decisions on the basis of medical necessity, the medical, behavioral health, and developmental care needs of the child should be fully considered and appropriate comprehensive benefits should be available to address the full range of these needs.ⁱⁱ

The proposed rule asserts that children and adolescents receiving MH/SUD services through the EPSDT benefit are deemed to have met the parity requirements for financial requirements and treatment limitations because annual or lifetime limits are not permissible in EPSDT benefits. We are concerned with this assertion and believe it may run counter to the spirit of mental health parity and addiction equity and congressional intent with the passage of the CHIP Reauthorization Act (CHIPRA). We are also concerned about its implications for children and adolescents in Medicaid EPSDT.

Based on the number of EPSDT class action lawsuits pertaining to the lack of diagnostic and treatment services for mental or behavioral health conditions in children and adolescents, **we do not agree that compliance with parity can be presumed in EPSDT.** As CMS finalizes the proposed rule, we encourage CMS to do more to ensure children and adolescents receive MH/SUD services in parity with medical and surgical care in EPSDT.

AAP recommends CMS require states to document that children and adolescents enrolled in FFS, MCOs, or carve-outs under Medicaid and CHIP have appropriate and timely access to the types of mental health and substance use providers they need. States should be required to document that their networks have sufficient participation by child and adolescent mental health and substance use providers and, when access problems exist, to document how they allow children and adolescents to seek care outside of those networks without financial penalties. This reporting requirement under Medicaid and CHIP should apply no matter what the state’s delivery system is.

As noted in the proposed rule, CHIPRA applies MH/SUD parity requirements to the entire “state child health plan” including, *but not limited to*, any MCOs that contract with the state CHIP. We are concerned with the continued allowance of NQTLs in CHIP even when the state covers the EPSDT benefit. We do not believe NQTL should apply in CHIP. Compliance with the parity requirements for NQTL in CHIP should be closely monitored by CMS.

As the final rule is implemented, we encourage CMS to ensure that states have a system in place to meaningfully engage pediatric providers on the changes that have been made

within Medicaid and CHIP in order to comply with MHPAEA and to receive feedback on and resolve concerns with parity compliance.

Long-term care services for children and adolescents

The proposed rule does not apply to children and adolescents in home and community-based waivers. We disagree with that approach given the MH/SUD needs of children with special health care needs. Given how many children with disabilities or chronic illness have co-occurring mental health or substance use disorders and the difficulties these children face obtaining needed services, **we recommend that the proposed rule retain long term care services for children and adolescents in the definition of medical/surgical services.** Many Medicaid-insured children and adolescents receive MH/SUD services in home and community-based alternative settings, including inpatient psychiatric services for individuals under age 21, because of the therapeutic significance of these treatment sites.

We applaud your efforts to construct a thoughtful proposal. Given the potential of MHPAEA to address some barriers to mental health and substance use disorder screening and treatment for children, **we urge you to move as quickly as possible to finalize the rule.** We appreciate that CMS has provided states a number of options to comply with MHPAEA, some that could be done fairly quickly. The proposed rule seeks comments on the 18-month compliance timeframe and we would urge CMS not to extend that timeframe any longer.

The AAP looks forward to working with CMS as it finalizes the proposed rule. Should you have any questions, please contact Tamar Magarik Haro in the AAP's Washington Office at (202) 347-8600 or at tharo@aap.org.

Sincerely,



Sandra G. Hassink, MD, FAAP
President

SGH/tmh

ⁱ AAP Committee on Child Health Finance. Medicaid Policy Statement. *Pediatrics*, 2013; 131; e1697

ⁱⁱ Ibid.



POLICY STATEMENT

Scope of Health Care Benefits for Children From Birth Through Age 26

COMMITTEE ON CHILD HEALTH FINANCING

KEY WORDS

ancillary services, diagnosis, durable medical equipment, emergency care, health care insurance benefits, hospitalization, preventive services, physician services, prescriptions, therapeutic services

ABBREVIATIONS

AAP—American Academy of Pediatrics

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abstract

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The optimal health of all children is best achieved with access to appropriate and comprehensive health care benefits. This policy statement outlines and defines the recommended set of health insurance benefits for children through age 26. The American Academy of Pediatrics developed a set of recommendations concerning preventive care services for children, adolescents, and young adults. These recommendations are compiled in the publication *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, third edition. The Bright Futures recommendations were referenced as a standard for access and design of age-appropriate health insurance benefits for infants, children, adolescents, and young adults in the Patient Protection and Affordable Care Act of 2010 (Pub L No. 114–148). *Pediatrics* 2012;129:185–189

This policy statement sets forth recommendations for the design of a comprehensive benefit package that covers infants, children, adolescents, and young adults through age 26 and is consistent with the Maternal and Child Health Plan Benefit Model: Evidence-Informed Coverage.¹ These benefit recommendations apply to all public and private health plans. The services outlined in this statement encompass medical care, preventive care, critical care, pediatric surgical care, behavioral health services, and oral health for all children, including those with special health care needs.

That payment schedules must cover the fixed and variable costs of providing the services is implied in the identification of services and products necessary to ensure the health of children. In addition, payments should be adequate so that physicians, pediatric service providers, and manufacturers will have continued incentive to remain in (or enter into) the business of caring for the health and developmental needs of children. Because of the variety and complexity of systems for delivering care and for providing payments, a complete discussion is beyond the scope of this statement; however, without adequate payment there is significant risk that children and families will be unable to access services and products needed to maintain and promote health in children. This risk is compounded by the recognition that health in adulthood is predicted by health in childhood. It is critical to stress that adequate payment for the provision of child health care services is a vital investment in life span health.

This statement replaces the 2006 statement “Scope of Health Care Benefits for Children from Birth Through Age 21.”²

ESSENTIAL BACKGROUND

All infants, children, adolescents, and young adults through 26 years of age must have access to comprehensive health care benefits to ensure their optimal health and well-being. These benefits must be available through Medicaid, the Children's Health Insurance Program (CHIP), and private health insurance plans, whether the plan sponsor is a commercial insurance company, a self-funded employer, or other arrangement. The Patient Protection and Affordable Care Act of 2010 (Pub L No. 111-148) also mandated the establishment of health insurance exchanges, wherein health plans must provide a minimum set of health benefits. The minimum health benefits for pediatrics include essential services, such as preventive care, hospitalization, ambulatory patient services, emergency medical services, maternity and newborn care, and mental health and substance abuse disorder services. Also included in the set of benefits are behavioral health, rehabilitative, and habilitative services and devices; laboratory services; chronic disease management; and oral, hearing, and vision care. Some of these benefits may be available or provided through the educational and public health systems for children with special needs and children who are uninsured or have inadequate coverage.

Health care benefits should begin with the full array of services recommended by the American Academy of Pediatrics (AAP). Coverage determinations of existing interventions should be based on evidence of usefulness and understanding of risks. Health care benefit coverage should reflect changes in treatment modalities and should adapt to new evidence and changes in standards of care, as well as innovations in care. Recognizing the importance of scientific evidence does not mean that coverage of existing interventions

should be denied in the absence of conclusive scientific evidence. If sufficient scientific evidence for an intervention is not available, professional standards of care must be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions must be based on consensus pediatric expert opinion (according to the AAP working definition in "Model Contractual Language for Medical Necessity for Children").³ The benefits should be delivered in an efficient manner by appropriately trained professionals, including primary care pediatricians and other generalists, pediatric medical subspecialists, pediatric surgical specialists, and pediatric dental professionals. These services should be delivered and coordinated in a comprehensive, patient- and family-centered, physician-led medical home—the setting for primary care delivered or directed by well-trained physicians who are known to the child and family, who have developed a partnership of mutual responsibility and trust with them, and who provide accessible, continuous, coordinated, and comprehensive care. These services should include but are not limited to the following broad categories: preventive services; physician/health care provider services; emergency care; hospitalization and other facility-based care; therapeutic services/durable medical equipment/ancillary services; and laboratory, diagnostic, assessment, and testing services.

PREVENTIVE SERVICES

Preventive services primarily assess risk factors for, or prevent the development of, medical conditions or developmental disorders that affect health or development. Preventive services include the following:

- A. Health supervision with comprehensive preventive care, according

to the AAP "Recommendations for Preventive Pediatric Health Care,"⁴ and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.⁵

- B. Immunizations according to recommendations included in the most current version of the "Recommended Childhood and Adolescent Immunization Schedules."⁶
- C. Educational, counseling, and support services for all children, including but not limited to the following:
 1. Anticipatory guidance relating to normal growth and development;
 2. Tobacco-cessation counseling and treatment services for children and/or household contacts; and
 3. Services related to the maintenance of a healthy weight—prevention, management, and treatment of pediatric obesity, malnutrition, eating disorders, or nutritional deficiency, including nutrition counseling and follow-up with physician or credentialed nutritionist and all necessary laboratory services, including evaluation of risk factors.
- D. Preventive pediatric oral health services, including the following:
 1. Oral health risk assessment, fluoride varnish, sealants, and similar preventive oral care;
 2. Provision of anticipatory guidance examinations and/or diagnostic investigations; and
 3. Oral surgery, including moderate sedation and general anesthesia services, as indicated, to treat oral health problems.
- E. Early intervention services for mental health/substance abuse.
- F. Preventive vision services, including screenings and examinations by individuals trained in the care of children for the purpose of

- early identification of vision problems.
- G. Preventive audiology services, including screening and evaluations by professionals trained in the care of children to provide early detection and diagnosis of hearing problems. These services include newborn and other age-appropriate hearing screenings.
- H. Preventive reproductive health services, including coverage for counseling and education to promote healthy choices regarding sexuality, as well as appropriate and effective means of minimizing risks of sexually transmitted diseases and preventing unintended pregnancy. Coverage should also be provided for transition of care to other specialists for treatment of pregnancy in young women or appropriate specialists for children with sexually transmitted diseases for whom treatment is beyond the scope of usual pediatric care.
- I. Preventive prenatal care, including prenatal consultation with a pediatrician, as well as counseling and services for all pregnancy and fetal management options, including evaluation of psychological risk factors that may affect the health and safety of the infant or family.
- J. Preventive postpartum care, including the following:
1. Newborn screening for metabolic and genetic disorders, as well as hearing screening and other appropriate tests;
 2. Prompt follow-up visit in the physician's office (as in between 48 and 72 hours following discharge) when indicated by the infant's condition and/or on the recommendation of the infant's physician;
 3. Lactation counseling to increase successful breastfeeding initiation and duration; and

4. A reasonable length of stay for the newborn infant to permit identification and treatment of early problems and to ensure that the family is able and prepared to care for the infant at home.

PHYSICIAN/HEALTH CARE PROVIDER SERVICES

Physician/health care provider services are delivered (1) in the primary care/medical home setting, (2) by a medical subspecialist or surgical specialist in coordination with the child's primary care physician, or (3) under the direction of the primary care physician in the patient's home or other setting. These services are directed toward diagnosis, appropriate treatment, rehabilitation, or palliative care of diseases and congenital or acquired health conditions. Physician/health care provider services include the following:

- A. Diagnosis and treatment of medical conditions.
- B. Educational counseling and support services for all children (see also the previous section on preventive services).
- C. Transition to adult medical care services for youth.
- D. Palliative and hospice care for children with serious or life-threatening conditions.
- E. Pediatric medical subspecialty services, including team subspecialty care, family planning, and reproductive services.
- F. Pediatric surgical care, including the following:
 1. Pediatric surgical care and surgical specialty services, including comprehensive repair of congenital anatomic malformations; and
 2. Anesthesia and acute and chronic pain management services provided by clinicians

with training and expertise in special considerations of pediatric anesthesia care.

- G. Behavioral health services, including the following:
1. Mental health services, including (a) diagnostic evaluation and care planning/coordination services; (b) age-appropriate counseling interventions, including individual, group, or family therapy; family-child interaction training; and behavioral therapy training; (c) psycho-educational testing; (d) crisis management; (e) inpatient and day treatment; and (f) residential care. These services should be covered for behavioral and mental health problems that occur in childhood, impair child or family function, threaten the future health of the child, or impair social relationships and/or academic success.
 2. Services for disorders relating to substance use, abuse, and dependence, including (a) screening, early intervention, and crisis management; (b) appropriate treatment interventions; (c) inpatient and outpatient treatment; and (d) residential care.
 3. Comprehensive medical and psychological evaluation, treatment, and care coordination for suspected or substantiated child physical, emotional, or sexual abuse and/or neglect in both inpatient and outpatient settings.
 4. Individual and family grief and bereavement counseling.
- H. Prenatal and neonatal services, including the following:
1. Genetic counseling and related services, as indicated;

2. Prenatal case management, including consultation with a pediatrician;
3. Care in response to complications resulting from problems during pregnancy, labor, or delivery;
4. Care of all newborn infants, including the following:
 - a. attendance of a pediatric- or neonatology-trained provider for management of high-risk deliveries or where mandated by hospital regulations;
 - b. health supervision;
 - c. treatment of congenital anomalies and other medical and surgical conditions; and
 - d. newborn intensive care services.
- l. Physician-directed, accurate pediatric medical information shared by telephone, telemedicine, e-mail, and/or other Internet services for established and new patients related to pediatric care. This information may include responses to patient or family questions, or may consist of outreach to specific patients relating information deemed important to their health, which may not merit the need for an office visit intervention. These communications should be compliant with regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA [Pub L No. 104-191]).
- J. Home health care services, where appropriate.
- K. Coverage of medical home- or physician-based care coordination and/or case management services (case management may be provided by a case manager or other qualified health care provider working collaboratively with the patient's family and health care team to develop, monitor, and revise a plan to meet the patient's immediate and ongoing health care needs; all children with

special health care needs and women with high-risk pregnancies should have access to and coverage for case-management services), including arrangement, coordination, sharing of information among care providers, and monitoring of health care and developmental services to meet the needs of a patient and his or her family.⁷

EMERGENCY CARE, HOSPITALIZATIONS, AND OTHER FACILITY-BASED CARE

These services address acute health care needs, ongoing illness, health or developmental conditions, or injury.

- A. Emergency medical and trauma services specifically for children. These services should be covered without regard to preferred provider networks or preferred facility designations, if facility selection is involuntary.
- B. Inpatient hospital and critical care services, including labor and delivery/birth center services, acute care, psychiatric care, inpatient rehabilitation, and substance abuse services.
- C. Intermediate or skilled nursing facility care in residential and rehabilitative/habilitative settings.
- D. Telemedicine services for emergency departments or inpatient facilities that do not have pediatric coverage for critically ill children.
- E. Emergent and nonemergent transfer/transport to a hospital or health facility, between health facilities, and between home and health facilities when indicated.

THERAPEUTIC SERVICES/DURABLE EQUIPMENT/ANCILLARY SERVICES

These include specialty services performed in the health care provider's

office or delivered in the patient's home or a health care facility, as well as products needed for maintenance of health or treatment of disease.

- A. Coverage for medications, biologics, or other compounds included in the US Pharmacopeia with evidence of safety and effectiveness for the treatment of specific conditions.
- B. Pediatric oral health services, including the following:
 1. Restorative pediatric dental care, including oral surgery with appropriate sedation or anesthesia as needed to correct dental or oral health problems; and
 2. Orthodontic services and appliances to correct problems with tooth and jaw alignment that contribute to other medical conditions.
- C. Vision services, including corrective lenses, surgery, or other treatments by professionals trained in the care of children, and access to pediatric ophthalmologists for treatment of medical conditions of the eye.
- D. Corrective audiology and speech therapy services, delivered by those trained in the care of children. These services include assistive technology (hearing aids, cochlear implants, and so forth) and speech therapy services for children with speech delay.
- E. Nutritional evaluation and counseling services by pediatricians, dietitians, nutritionists, and other therapists for eating disorders (including primary obesity, anorexia, and bulimia) and specific nutritional deficiencies.
- F. Special diets, infant formulas, nutritional supplements, and delivery (feeding) devices for nutritional

- support and disease-specific metabolic needs.
- G. Physical, occupational, speech (including speech-generating devices), and respiratory therapy for rehabilitation and habilitation provided in medical centers, private/public-sector offices, schools, residential settings, and the home.
 - H. Home health care services, including but not limited to physician supervision of care, therapies, private-duty nursing, and home health aides.
 - I. Rehabilitative and habilitative services and devices.
 - J. Rental, purchase, maintenance, and service of durable medical equipment, including but not limited to the following:
 1. Equipment necessary to administer aerosolized medications and monitor their effects (nebulizer, spacers for inhalers, peak flow meters);
 2. Glucometers, insulin pumps, and enteral nutrition pumps;
 3. Breast pumps and accessories;
 4. Prostheses/braces, wheelchairs, lifts, and other mobility aids;
 5. Ventilators, positive airway pressure devices, and other pulmonary treatment and monitoring equipment;
 6. Cardiorespiratory monitors, such as pulse oximeters or apnea monitors;
 7. Home dialysis equipment;
 8. Automated home blood pressure monitors; and
 9. Equipment for home-based treatment of newborn jaundice.
 - K. Disposable medical supplies, including but not limited to the following:
 1. Diapers for developmentally compromised patients;
 2. Urine catheters and ostomy supplies;
 3. Tracheostomy care needs, suction catheters for managing pulmonary secretions, and other tubing and/or mask needs;
 4. Tubing for delivering intravenous or enteral fluids; and
 5. Test strips, lancets, syringes, needles, insulin pump supplies, and other diabetic supplies.
 - L. Respite services for caregivers of children with special health care needs.

LABORATORY, DIAGNOSTIC, ASSESSMENT, AND TESTING SERVICES

These include services that determine the risk, presence, severity, prognosis,

or cause of an illness or testing for diagnosing a specific illness, injury, or disability.

- A. Laboratory and pathology services.
- B. Diagnostic, assessment, and therapeutic services, such as radiology services, and including age-appropriate sedation as needed.
- C. Standardized assessment and monitoring tools for identification, diagnosis, and monitoring of educational, developmental, behavioral, and mental health conditions.

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