Attachment XVIII

- CMS-416 Report for FFY 2009

Boone, Anne

From: Boone, Anne
Sent: Thursday, April 01, 2010 11:37 AM
To: 'EPSDT@cms.hhs.gov.'
Cc: 'Ruff.Cynthia@cms.hhs.gov'; Cartwright, Catherine A. (CMS/SC)
Subject: Florida's CMS-416 Report for FFY 2009
Attachments: CMS-416 cover letter 4_1_10 (2).pdf; FL CMS-416 FFY2009.xlsx; Document (20).pdf

Good Morning Cindy and Catherine,

Please find attached Florida's Annual CMS-416 Report, cover letter and periodicity schedule.

If you have any questions please do not hesitate to call me at (850) 412-4220 or by email at Anne.Boone@ahca.myflorida.com.

Thank you very much,
Anne

Anne Boone, ARNP
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Florida Bureau of Medicaid Services - Child Health Services
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Tracking:

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

March 31, 2010

Ms. Jackie L. Glaze
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Atlanta Regional Office in Region IV
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303-8909

Dear Ms. Glaze:

I am submitting Florida's Annual Child Health Check-Up (formerly known as the Early and Periodic Screening, Diagnosis and Treatment) Participation Report, CMS-416 and periodicity schedule, for the time period October 1, 2008, through September 30, 2009. We are pleased to report that the participation rate continues to increase. For those areas where participation is not at the 80 percent goal, we are continuing to address ways to improve the rates.

Please note that we are unable to capture on this report fluoride varnish services provided to eligibles during an office visit or a Child Health Check-Up. Florida Medicaid uses the Current Procedural Terminology (CPT) code 99499 SC, not a dental code, for preventive services provided by non-dentists.

We would again like to suggest that the Centers for Medicare and Medicaid Services consider requiring all states to follow the Bright Futures/American Academy of Pediatrics "Recommendations for Preventive Pediatric Health Care" (Periodicity Schedule) as a quality standard for the Early and Periodic Screening, Diagnosis and Treatment program. This would ensure consistency in the frequency of preventive care visits across all states.

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FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

State Code	Fiscal Year								
FL	2009	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1. Total individuals eligible for EPSDT	CN:	1,850,056	142,054	290,445	343,415	358,397	368,807	267,294	79,644
	MN:	18,507	511	767	1,174	2,753	4,170	4,368	4,764
	Total:	1,868,563	142,565	291,212	344,589	361,150	372,977	271,662	84,408
2a. State Periodicity Schedule			6	4	3	2	5	4	2
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			6.00	2.00	1.00	0.50	1.00	1.00	1.00
3a. Total Months of Eligibility	CN:	17,248,633	887,528	2,846,153	3,365,179	3,463,571	3,526,500	2,511,882	647,820
	MN:	33,014	1,979	1,820	1,626	4,156	6,615	7,224	9,594
	Total:	17,281,647	889,507	2,847,973	3,366,805	3,467,727	3,533,115	2,519,106	657,414
3b. Average Period of Eligibility	CN:	0.76	0.52	0.82	0.82	0.81	0.80	0.78	0.68
	MN:	0.15	0.32	0.20	0.12	0.13	0.13	0.14	0.17
	Total:	0.77	0.52	0.81	0.81	0.80	0.79	0.77	0.65
4. Expected Number of Screenings per Eligible	CN:		3.12	1.64	0.82	0.41	0.80	0.78	0.68
	MN:		1.92	0.40	0.12	0.07	0.13	0.14	0.17
	Total:		3.12	1.62	0.81	0.40	0.79	0.77	0.65
5. Expected Number of Screenings	CN:	1,905,774	443,208	476,330	281,600	146,943	295,046	208,489	54,158
	MN:	3,586	981	307	141	193	542	612	810
	Total:	1,909,360	444,189	476,637	281,741	147,136	295,588	209,101	54,968
6. Total Screens Received	CN:	1,646,727	617,558	397,798	238,827	149,095	154,997	79,668	8,784
	MN:	8,191	4,725	975	432	579	786	497	197
	Total:	1,654,918	622,283	398,773	239,259	149,674	155,783	80,165	8,981
7. SCREENING Ratio	CN:	0.86	1.00	0.84	0.85	1.00	0.53	0.38	0.16
	MN:	1.00	1.00	1.00	1.00	1.00	1.00	0.81	0.24
	Total:	0.87	1.00	0.84	0.85	1.00	0.53	0.38	0.16

Recommendations for Preventive Pediatric Health Care (RE9535)

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY[4]									EARLY CHILDHOOD[4]					MIDDLE CHILDHOOD[4]				ADOLESCENCE[4]										
AGE[5]	PRENATAL[1]	NEWBORN[2]	2-4d[3]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY																													
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																													
Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																	
Blood Pressure													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																													
Vision		S	S	S	S	S	S	S	S	S	S	S	O[6]	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
Hearing		O[7]	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT[8]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[9]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-GENERAL[10]																													
Hereditary/Metabolic Screening[11]		←•	•→							•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Immunization[12]		•	•	•	•	•	•	•	•	←•					→•				←•		•[14]			•[15]					•→
Hematocrit or Hemoglobin[13]								•→																					
Urinalysis															•				←•					•→					•→
PROCEDURES-PATIENTS AT RISK																													
Lead Screening[16]								→•				*																	
Tuberculin Test[17]									*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening[18]												*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
STD Screening[19]															*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Pelvic Exam[20]																			*	*	*	*	*	*	*	*→	*[20]	*→	*→
ANTICIPATORY GUIDANCE[21]																													
Injury Prevention[22]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Violence Prevention[23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling[24]	•	•	•	•	•	•	•																						
Nutrition Counseling[25]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL[26]									←•					→•															

1. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1990).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the patient is uncooperative, rescreen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement, "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
8. By history and appropriate physical examination if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP *Pediatric Nutrition Handbook* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States. *MMWR*. 1998;47 (RR-3):1-29.
14. All menstruating adolescents should be surveyed annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active patients should be screened for sexually transmitted diseases (STDs).
20. All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP *Guidelines for Health Supervision III* (1998).
22. From birth to age 12, refer to the AAP injury prevention program (TIPP®) as described in *A Guide to Safety Counseling in Office Practice* (1994).
23. Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Positioning and Sudden Infant Death Syndrome (SIDS): Update" (1996).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Handbook of Nutrition* (1998).
26. Earlier initial dental examinations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key: • = to be performed; * = to be performed for patients at risk; S = subjective, by history; O = objective, by a standard testing method; ←•→ = the range during which a service may be provided, with the dot indicating the preferred age.

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc) is discretionary with the physician.

American Academy of Pediatrics