Attachment XVII

- CMS-416 Report for FFY 2008

Boone, Anne

From: Johnson, Andriette E. (CMS/SC) [Andriette.Johnson@cms.hhs.gov]
Sent: Wednesday, April 29, 2009 9:26 AM
To: Boone, Anne
Cc: Ruff, Cynthia L. (CMS/CMSO)
Subject: RE: Florida's CMS-416 Report

Thank you Anne for sending the report and notifying us. We also understood the reason for the delay.

Have a wonderful day
Andriette

From: Boone, Anne [mailto:boonea@ahca.myflorida.com]
Sent: Wednesday, April 29, 2009 9:17 AM
To: EPSDT@cms.hhs.gov.
Cc: Ruff, Cynthia L. (CMS/CMSO); Johnson, Andriette E. (CMS/SC)
Subject: Florida's CMS-416 Report

Good Morning Cindy and Andriette,

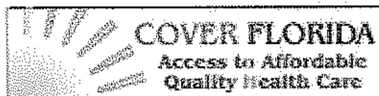
Please find attached Florida's Annual CMS -416 Report, cover letter and the Child Health Check-Up periodicity schedule. Again we apologize for the delay in submission of this year's report.

If you have any questions please do not hesitate to call me at (850) 922-7321.

Thank you very much,

Anne Boone

Agency for Health Care Administration
Florida Bureau of Medicaid Services - Child Health Services
2727 Mahan Drive - Mail Stop 20
Tallahassee, Florida 32308
850.922.7321; fax 850.414.1721
boonea@ahca.myflorida.com



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FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

April 28, 2009

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
CMS - Atlanta Regional Office
61 Forsyth Street, SW
Atlanta, GA 30303

Dear Ms. Justis:

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, for the time period October 1, 2007 through September 30, 2008. We apologize for the delay in sending the report. We are submitting the report in the electronic format as requested, and are pleased to show that there continues to be an increase in both our participation rate and screening rate. For age groups not at the 80 percent goal, we continue to address ways to improve these rates.

Please note that we are unable to capture 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 like to suggest the Centers for Medicare and Medicaid Services consider having all states use 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. As requested, Florida's Child Health Check-Up periodicity schedule following the recommendations of the American Academy of Pediatrics is enclosed.

Mary Kaye Justis
April 28, 2009
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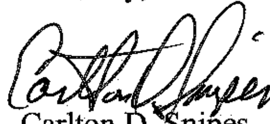
If you have any questions, please call Anne Boone of my staff at (850) 922-7321 or Hazel Greenberg in the Bureau of Managed Health Care at (850) 414-9444.

Sincerely,



Carlton D. Snipes
Deputy Secretary for Medicaid

CDS/ab/ah
Enclosures
cc: Cindy Ruff, CMS Central Office
Andriette Johnson, CMS Region IV
Tom Warring, Chief, Bureau of Managed Health Care
Melanie Brown-Woofter, Chief, Bureau of Health Systems Development
Karen Chang, AHC Administrator, Medicaid Program Analysis
Hazel Greenberg, HMO Data Unit, Bureau of Managed Health Care
Mary Cerasoli, Program Analyst
Area Medicaid Field Office Managers 1-11
Area Medicaid Child Health Check-Up Coordinators 1-11

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code: FL

Fiscal Year: 2008

		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:	1,640,829	140,398	266,947	293,610	316,033	320,718	236,169	66,954
	MN:	14,014	580	612	966	2,168	3,177	3,413	3,098
	Total:	1,654,843	140,978	267,559	294,576	318,201	323,895	239,582	70,052
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:	15,067,464	943,190	2,536,497	2,831,193	3,004,150	3,051,282	2,196,025	505,127
	MN:	25,825	1,883	1,238	1,527	3,486	5,514	6,019	6,158
	Total:	15,093,289	945,073	2,537,735	2,832,720	3,007,636	3,056,796	2,202,044	511,285
3b. Average Period of Eligibility	CN:	0.77	0.56	0.79	0.80	0.79	0.79	0.77	0.63
	MN:	0.15	0.27	0.17	0.13	0.13	0.14	0.15	0.17
	Total:	0.76	0.56	0.79	0.80	0.79	0.79	0.77	0.61
4. Expected Number of Screenings per Eligible	CN:		3.36	1.58	0.80	0.40	0.79	0.77	0.63
	MN:		1.62	0.34	0.13	0.07	0.14	0.15	0.17
	Total:		3.36	1.58	0.80	0.40	0.79	0.77	0.61
5. Expected Number of Screenings	CN:	1,732,212	471,737	421,776	234,888	126,413	253,367	181,850	42,181
	MN:	2,910	940	208	126	152	445	512	527
	Total:	1,735,122	472,677	421,984	235,014	126,565	253,812	182,362	42,708
6. Total Screens Received	CN:	1,522,452	643,770	354,752	203,307	123,602	126,928	63,779	6,314
	MN:	2,195	1,794	137	49	54	70	45	46
	Total:	1,524,647	645,564	354,889	203,356	123,656	126,998	63,824	6,360
	CN:	0.88	1.00	0.84	0.87	0.98	0.50	0.35	0.15

7. SCREENING Ratio	MN:	0.75	1.00	0.66	0.39	0.36	0.16	0.09	0.09
	Total:	0.88	1.00	0.84	0.87	0.98	0.50	0.35	0.15
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	1,246,044	140,398	266,947	234,888	126,413	253,367	181,850	42,181
	MN:	2,550	580	208	126	152	445	512	527
	Total:	1,248,594	140,978	267,155	235,014	126,565	253,812	182,362	42,708
9. Total Eligibles Receiving at One Initial or Periodic Screen	CN:	870,225	234,709	179,149	170,591	112,151	112,822	55,371	5,432
	MN:	928	609	77	48	50	61	43	40
	Total:	871,153	235,318	179,226	170,639	112,201	112,883	55,414	5,472
10. PARTICIPANT RATIO	CN:	0.70	1.00	0.67	0.73	0.89	0.45	0.30	0.13
	MN:	0.36	1.00	0.37	0.38	0.33	0.14	0.08	0.08
	Total:	0.70	1.00	0.67	0.73	0.89	0.44	0.30	0.13
11. Total Eligibles Referred for Corrective Treatment	CN:	84,049	19,293	24,066	15,328	9,594	9,961	5,209	598
	MN:	43	26	2	2	1	8	3	1
	Total:	84,092	19,319	24,068	15,330	9,595	9,969	5,212	599
12a. Total Eligibles Receiving Any Dental Services	CN:	345,831	677	15,924	82,925	101,058	88,190	50,665	6,392
	MN:	187	0	4	9	46	40	32	56
	Total:	346,018	677	15,928	82,934	101,104	88,230	50,697	6,448
12b. Total Eligibles Receiving Preventive Dental Services	CN:	227,433	245	9,792	52,724	68,262	60,518	32,235	3,657
	MN:	115	0	1	6	33	24	17	34
	Total:	227,548	245	9,793	52,730	68,295	60,542	32,252	3,691
12c. Total Eligibles Receiving Dental Treatment Services	CN:	128,845	194	4,461	27,262	38,847	32,944	22,056	3,081
	MN:	76	0	1	3	24	11	12	25
	Total:	128,921	194	4,462	27,265	38,871	32,955	22,068	3,106
13. Total Eligibles Enrolled in Managed Care	CN:	1,455,890	100,120	251,620	271,604	287,717	286,569	203,709	54,551
	MN:	268	0	86	158	0	2	6	16
	Total:	1,456,158	100,120	251,706	271,762	287,717	286,571	203,715	54,567
14. Total Number of Screening Blood Lead Tests	CN:	100,796	7,610	63,235	29,951				
	MN:	36	4	22	10				
	Total:	100,832	7,614	63,257	29,961				

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]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin[13]								•	→	★					→				←		•[14]								→
Urinalysis															•				←					•[15]					→
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" (1996).
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 screened 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.

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