Attachment XV

- CMS-416 Report for FFY 2006

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

July 5, 2007

Renard L. Murray, D.M.
Associate Regional Administrator
CMS Region IV - Division of Medicaid
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303-8909

Dear Dr. Murray:

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, 2005 through September 30, 2006. We apologize for the delay in the submission of this report. We have been timely in the annual submission of the reports in the past and regret this delay.

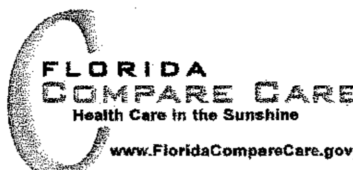
We are pleased to report that there continues to be an increase in both our participation rate (62 percent) and screening rate (78 percent). The participation and screening rates for the age groups <1, 1-2 years, and 6-9 years have reached the federal 80 percent goal.

We would like to suggest for the Centers for Medicare and Medicaid Services (CMS) consideration that all states use the 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.

We would again like to recommend that CMS consider allowing the HMOs to use the HEDIS mix-model approach to the calculation of rates rather than relying totally on claims data. To support this recommendation, the enclosed final 2006 Report on "The Florida KidCare Evaluation Series" for the same time-period shows well-child visit compliance at 90 percent for enrollees age two and over. The well-child rates are higher than identified on this CMS-416 report.

As requested, enclosed is Florida's Child Health Check-Up periodicity schedule that follows the recommendations of the American Academy of Pediatrics.

2727 Mahan Drive, MS#8
Tallahassee, Florida 32308



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,

Thomas W. Amold
Deputy Secretary for Medicaid

TWA/AB/ah
Enclosures
cc/enc: Jean K. Sheil, Director, Family and Children's Health Programs, CMS Central Office
Cindy Ruff, CMS Central Office
Catherine Cartwright, CMS Region IV
Tom Warring, Chief, Bureau of Managed Health Care

ANNUAL CHILD HEALTH CHECK-UP PARTICIPATION REPORT CMS-416

10/01/05 - 09/30/06

STATE: FLORIDA FY: 2006	CAT	TOTAL	AGE GROUPS < 1	1 - 2	3 - 5	6 - 9	10 - 14	15 - 18	19 - 20
1. TOTAL INDIVIDUALS ELIGIBLE FOR CHCUP:	CN	1,671,716	138,062	251,081	297,130	326,751	346,675	249,867	62,150
	MN	19,430	1,552	1,905	1,164	2,907	3,883	4,116	3,903
	TOTAL	1,691,146	139,614	252,986	298,294	329,658	350,558	253,983	66,053
2A. STATE PERIODICITY SCHEDULE			6.00	4.00	3.00	2.00	5.00	4.00	2.00
2B. NUMBER OF YEARS IN AGE GROUP			1.00	2.00	3.00	4.00	5.00	4.00	2.00
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	15,385,127	848,024	2,430,594	2,919,210	3,087,618	3,286,848	2,325,489	487,344
	MN	71,237	9,161	11,102	3,840	9,037	11,761	11,958	14,378
	TOTAL	15,456,364	857,185	2,441,696	2,923,050	3,096,655	3,298,609	2,337,447	501,722
3B. AVERAGE PERIOD OF ELIGIBILITY	CN	0.77	0.51	0.81	0.82	0.79	0.79	0.78	0.65
	MN	0.31	0.49	0.49	0.27	0.26	0.25	0.24	0.31
	TOTAL	0.76	0.51	0.80	0.82	0.78	0.78	0.77	0.63
4. EXPECTED NUMBER OF OF SCREENINGS PER ELIGIBLE	CN		3.06	1.62	0.82	0.40	0.79	0.78	0.65
	MN		2.94	0.98	0.27	0.13	0.25	0.24	0.31
	TOTAL		3.06	1.60	0.82	0.39	0.78	0.77	0.63
5. EXPECTED NUMBER SCREENINGS	CN	1,712,735	422,470	406,751	243,647	130,700	273,873	194,896	40,398
	MN	10,291	4,563	1,867	314	378	971	988	1,210
	TOTAL	1,723,026	427,033	408,618	243,961	131,078	274,844	195,884	41,608
6. TOTAL SCREENS RECEIVED	CN	1,335,396	407,550	445,109	186,148	112,377	117,810	60,991	5,411
	MN	6,344	3,842	2,014	90	126	144	93	35
	TOTAL	1,341,740	411,392	447,123	186,238	112,503	117,954	61,084	5,446
7. SCREENING RATIO	CN	0.78	0.96	1.09	0.76	0.86	0.43	0.31	0.13
	MN	0.62	0.84	1.08	0.29	0.33	0.15	0.09	0.03
	TOTAL	0.78	0.96	1.09	0.76	0.86	0.43	0.31	0.13
8. TOTAL ELIGIBLES WHO SHOULD RECEIVE AT LEAST ONE INITIAL OR PERIODIC SCREEN	CN	1,272,657	138,062	251,081	243,647	130,700	273,873	194,896	40,398
	MN	7,280	1,552	1,867	314	378	971	988	1,210
	TOTAL	1,279,937	139,614	252,948	243,961	131,078	274,844	195,884	41,608
9. TOTAL ELIGIBLES RECEIVING AT LEAST ONE INTIAL OR PERIODIC SCREEN	CN	785,234	149,322	201,619	163,313	103,921	107,956	54,407	4,696
	MN	2,497	1,181	852	87	120	130	92	35
	TOTAL	787,731	150,503	202,471	163,400	104,041	108,086	54,499	4,731
10. PARTICIPANT RATIO	CN	0.62	1.08	0.80	0.67	0.80	0.39	0.28	0.12
	MN	0.34	0.76	0.46	0.28	0.32	0.13	0.09	0.03
	TOTAL	0.62	1.08	0.80	0.67	0.80	0.39	0.28	0.12

***** CONTINUED ON NEXT PAGE *****

ANNUAL CHILD HEALTH CHECK-UP PARTICIPATION REPORT CMS-416
10/01/05 - 09/30/06

STATE: FLORIDA FY: 2006		CAT		AGE GROUPS						
			TOTAL	< 1	1 - 2	3 - 5	6 - 9	10 - 14	15 - 18	19 - 20
11.	TOTAL ELIGIBLES	CN	181,998	28,382	61,986	36,146	19,515	21,532	12,642	1,795
	REFERRED FOR	MN	10	3	3	1	0	1	0	2
	CORRECTIVE TREATMENT	TOTAL	182,008	28,385	61,989	36,147	19,515	21,533	12,642	1,797
12A.	TOTAL ELIGIBLES	CN	351,826	251	9,980	77,204	103,098	96,613	56,282	8,398
	RECEIVING ANY DENTAL	MN	915	1	6	57	227	239	192	193
	SERVICES	TOTAL	352,741	252	9,986	77,261	103,325	96,852	56,474	8,591
12B.	TOTAL ELIGIBLES	CN	224,274	69	5,841	47,857	68,319	65,259	33,058	3,871
	RECEIVING PREVENTIVE	MN	491	0	4	32	146	135	97	77
	DENTAL SERVICES	TOTAL	224,765	69	5,845	47,889	68,465	65,394	33,155	3,948
12C.	TOTAL ELIGIBLES	CN	132,076	98	3,023	24,908	38,469	36,523	25,178	3,877
	RECEIVING DENTAL	MN	336	0	0	15	65	76	84	96
	TREATMENT SERVICES	TOTAL	132,412	98	3,023	24,923	38,534	36,599	25,262	3,973
13.	TOTAL ELIGIBLES	CN	1,491,423	96,895	232,253	274,854	299,687	314,951	219,232	53,551
	ENROLLED IN	MN	34	19	2	0	0	1	3	9
	MANAGED CARE	TOTAL	1,491,457	96,914	232,255	274,854	299,687	314,952	219,235	53,560
14.	TOTAL NUMBER OF	CN	83,820	3,242	49,610	30,968				
	SCREENING BLOOD	MN	166	14	145	7				
	LEAD TESTS	TOTAL	83,986	3,256	49,755	30,975				

***** END OF REPORT *****

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.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright ©1999 by the American Academy of Pediatrics. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.

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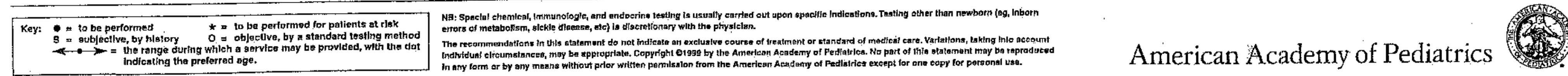

14 Compliance with Preventive Care Guidelines

AT A GLANCE

■ **Ninety percent of parents of established KidCare enrollees reported their child received a routine visit during the twelve months prior to the interview.**

WELL-CHILD VISIT COMPLIANCE

The American Academy of Pediatrics (AAP) and others have established guidelines for the appropriate number of well-child/preventive care visits. Beginning at two years of age, children are expected to have annual well-child visits. Prior to two years of age, multiple visits are recommended at predetermined intervals. Ninety percent of parents of established KidCare enrollees reported their child received a routine visit during the twelve months prior to the interview. All programs have high compliance with this guideline, with 88 percent of Medicaid HMO, 89 percent of Healthy Kids, 93 percent of MediPass, 95 percent of MediKids, and 98 percent of CMSN enrollees compliant with this guideline.

BODY MASS INDEX

Parents were asked to self-report their best estimate of their child's height and weight during the telephone interview. The Body Mass Index (BMI) was calculated using the parent's estimate of height and weight for each child over the age of two years. Unlike BMI for adults, there are not well-defined cutpoints for children's BMI denoting a healthy weight or obesity. Growth spurts vary by age and gender, but a BMI of 30 or greater is generally considered to be obese, regardless of age or gender. Average BMIs by program are presented in Table 25 and Figure 22.

About 12 percent of KidCare enrollees have BMIs of 30 or greater. This share is larger than the 9 percent and 8 percent found in the prior two KidCare evaluations. Variations were found by program and race-ethnicity. Fourteen percent of Medicaid HMO enrollees are obese compared to 11 percent of MediPass and Healthy Kids enrollees, 10 percent of CMSN, and 4 percent of MediKids. Fourteen percent of Hispanic children are obese compared to 13 percent of black children and 11 percent of non-Hispanic white children. Obesity levels were highest among black children in CMSN (26 percent) and white non-Hispanic children in Medicaid HMO (17 percent). ■