Illinois' CMS-416 Reporting of Early and Periodic Screening, Diagnosis and Treatment Services for Children

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive federal-state program that provides initial and periodic examinations and medically necessary follow-up to low-income children under age 21 who are enrolled in Medicaid. The EPSDT program includes medical, dental, vision, and hearing services.

Annually, states report on EPSDT services to the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) using Form CMS-416. CMS requires states to complete Form CMS-416 based on guidance it provides to ensure consistency in reporting. The CMS-416 report is filed electronically and includes basic information on participation of children in Medicaid. Each state reports on the number of children by age group who are provided child health screening services, referred for corrective treatment, and receiving dental services.

For federal fiscal year 2010 (October 1, 2009 through September 30, 2010) reporting, Illinois used the version of the CMS guidance that was finalized in March 2010. (CMS released revised guidance in June 2010. That version will be used for reporting federal fiscal year 2011 results.)

Illinois' CMS-416 report for federal fiscal year 2010 (October 1, 2009 through September 30, 2010) and the federal guidance for completing the report follow.

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code IL

Fiscal Year 2010

		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
1a. Total individuals eligible for EPSDT	CN:	1,620,948	80,134	206,751	293,398	338,028	357,192	262,625	82,820
	MN:	9,657	42	685	1,748	2,481	2,769	1,777	155
	Total:	1,630,605	80,176	207,436	295,146	340,509	359,961	264,402	82,975
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	1,563,534	64,908	201,884	287,317	330,904	349,208	255,856	73,457
	MN:	8,879	33	603	1,604	2,305	2,576	1,640	118
	Total:	1,572,413	64,941	202,487	288,921	333,209	351,784	257,496	73,575
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	7,573	0	4	171	1,452	1,540	1,334	3,072
	MN:	0	0	0	0	0	0	0	0
	Total:	7,573	0	4	171	1,452	1,540	1,334	3,072
2a. State Periodicity Schedule			6	4	3	2	3	2	1
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	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	17,731,023	472,832	2,338,691	3,359,747	3,871,238	4,077,571	2,952,452	658,492
	MN:	89,891	151	5,400	16,087	23,867	26,610	16,844	932
	Total:	17,820,914	472,983	2,344,091	3,375,834	3,895,105	4,104,181	2,969,296	659,424
3b. Average Period of Eligibility	CN:	0.95	0.61	0.97	0.97	0.97	0.97	0.96	0.75
	MN:	0.84	0.38	0.75	0.84	0.86	0.86	0.86	0.66
	Total:	0.94	0.61	0.96	0.97	0.97	0.97	0.96	0.75
4. Expected Number of Screenings per Eligible	CN:		3.66	1.94	0.97	0.49	0.58	0.48	0.38
	MN:		2.28	1.50	0.84	0.43	0.52	0.43	0.33
	Total:		3.66	1.92	0.97	0.49	0.58	0.48	0.38
5. Expected Number of Screenings	CN:	1,423,324	237,563	391,655	278,697	162,143	202,541	122,811	27,914
	MN:	5,402	75	905	1,347	991	1,340	705	39
	Total:	1,428,726	237,638	392,560	280,044	163,134	203,881	123,516	27,953
6. Total Screens Received	CN:	1,631,565	439,876	366,048	297,435	156,632	234,615	121,629	15,330
	MN:	3,869	181	674	979	516	1,095	422	2
	Total:	1,635,434	440,057	366,722	298,414	157,148	235,710	122,051	15,332
7. SCREENING RATIO	CN:	1.00	1.00	0.93	1.00	0.97	1.00	0.99	0.55
	MN:	0.72	1.00	0.74	0.73	0.52	0.82	0.60	0.05
	Total:	1.00	1.00	0.93	1.00	0.96	1.00	0.99	0.55
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	1,060,898	64,908	201,884	278,697	162,143	202,541	122,811	27,914
	MN:	5,058	33	603	1,347	991	1,340	705	39
	Total:	1,065,956	64,941	202,487	280,044	163,134	203,881	123,516	27,953

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code IL

Fiscal Year 2010

		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
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	800,840	58,435	163,076	190,002	119,791	160,080	87,558	21,898
	MN:	2,752	19	346	735	453	812	377	10
	Total:	803,592	58,454	163,422	190,737	120,244	160,892	87,935	21,908
10. PARTICIPANT RATIO	CN:	0.75	0.90	0.81	0.68	0.74	0.79	0.71	0.78
	MN:	0.54	0.58	0.57	0.55	0.46	0.61	0.53	0.26
	Total:	0.75	0.90	0.81	0.68	0.74	0.79	0.71	0.78
11. Total Eligibles Referred for Corrective Treatment	CN:	283,987	30,331	38,488	59,455	53,964	70,296	27,806	3,647
	MN:	859	15	107	217	145	294	81	0
	Total:	284,846	30,346	38,595	59,672	54,109	70,590	27,887	3,647
12a. Total Eligibles Receiving Any Dental Services	CN:	739,929	1,720	51,511	175,045	220,070	192,658	90,841	8,084
	MN:	3,413	0	99	668	1,134	1,090	420	2
	Total:	743,342	1,720	51,610	175,713	221,204	193,748	91,261	8,086
12b. Total Eligibles Receiving Preventive Dental Services	CN:	695,940	1,224	45,994	165,450	211,793	184,560	81,231	5,688
	MN:	3,214	0	86	618	1,085	1,040	383	2
	Total:	699,154	1,224	46,080	166,068	212,878	185,600	81,614	5,690
12c. Total Eligibles Receiving Dental Treatment Services	CN:	279,158	51	4,852	53,305	92,626	75,927	47,410	4,987
	MN:	1,329	0	9	210	467	437	205	1
	Total:	280,487	51	4,861	53,515	93,093	76,364	47,615	4,988
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	143,771				78,958	64,813		
	MN:	799				412	387		
	Total:	144,570				79,370	65,200		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	668,490	1,675	49,507	160,864	197,565	172,082	79,657	7,140
	MN:	3,048	0	93	610	1,018	969	357	1
	Total:	671,538	1,675	49,600	161,474	198,583	173,051	80,014	7,141
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	6,422	1,051	5,253	118	0	0	0	0
	MN:	4	0	4	0	0	0	0	0
	Total:	6,426	1,051	5,257	118	0	0	0	0
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	527,005	942	34,930	123,976	163,529	142,134	57,762	3,732
	MN:	2,411	0	62	467	838	780	263	1
	Total:	529,416	942	34,992	124,443	164,367	142,914	58,025	3,733
13. Total Eligibles Enrolled in Managed Care	CN:	186,782	7,231	24,117	35,506	39,902	41,600	29,572	8,854
	MN:	147	0	11	18	47	37	31	3
	Total:	186,929	7,231	24,128	35,524	39,949	41,637	29,603	8,857
14. Total Number of Screening Blood Lead Tests	CN:	458,058	61,175	204,625	192,258				
	MN:	874	63	332	479				
	Total:	458,932	61,238	204,957	192,737				

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

The completed report demonstrates the State's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decision and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each State that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. This data must include services provided under both fee-for-service and capitated managed care arrangements. Each State is required to collect encounter data (or other data as necessary) from managed care entities in sufficient detail to provide the information required by this report. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416 effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990. This version of the form must be used effective fiscal year 2010 for data due on or after April 1, 2011.

D. Submittal Procedure – States should submit the annual form CMS–416 and your State periodicity schedule electronically to the CMS central office via the EPSDT mailbox at **EPSDT@cms.hhs.gov** not later than April 1 of the year following the end of the Federal fiscal year being reported. The electronic form and instructions are available on the CMS website a**t http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage.** A "hard copy" submittal to CMS is no longer required.

E. Detailed Instructions -- For each of the following line items, report total counts by the age groups indicated and by whether categorically and medically needy. In cases where calculations are necessary, perform separate calculations for the total column and each age group. **Report age based upon the child's age as of September 30.**

State. Enter the name of your State using the two character State code in upper case format.

Fiscal Year. Enter the Federal fiscal year (FY) being reported in YYYY format.

Line 1a – **Total Individuals Eligible for EPSDT –** Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age and by basis of eligibility. "Unduplicated" means that an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. Include all individuals regardless of whether the services are provided under fee-for-service arrangements or managed care arrangements. States should determine the basis of eligibility consistent with the instructions for form CMS-2082. Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services regardless of whether they have been informed about the availability of EPSDT services or whether they accept EPSDT services at the time of informing. Individuals for whom third-party liability is available should also be counted in the number.

Do not include in this count the following groups of individuals: 1) medically needy individuals under the age of 21 if you do not provide EPSDT services for the medically needy population; 2) individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available; 3) undocumented aliens who are eligible only for emergency Medicaid services; or 4) other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

Line 1b -- Total Individuals Eligible for EPSDT for 90 Continuous Days -- Enter the total unduplicated number of individuals under the age of 21 from line 1a who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days and determined to be eligible for EPSDT services, distributed by age and by basis of eligibility.

Line 1c – Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program – Enter the number of individuals **included in line 1b** who are under the age of 21 and eligible for EPSDT services as part of a CHIP Medicaid expansion program. For children who have been eligible for EPSDT under both Medicaid and a CHIP Medicaid expansion program during the report year, include the child on this line of they are enrolled in CHIP as of September 30.

Line 2a - State Periodicity Schedule -- Enter the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the State's periodicity schedule. (Example: If your State periodicity schedule requires screening at 12, 18 and 24 months, the number 3 should be entered in the 1-2 age group column.) **Make no entry in the total column.**

Note: Use the State's most recent periodicity schedule and attach a copy to the completed report for submittal to CMS.

Line 2b - Number of Years in Age Group -- Make no entries on this line. This is a fixed number reflecting the number of years included in each age group.

Line 2c - Annualized State Periodicity Schedule -- Divide line 2a by the number in line 2b. Enter the quotient. This is the number of screenings expected to be received by an individual in each age group in one year. **Make no entry in the total column.**

Line 3a - Total Months of Eligibility -- Enter the total months of eligibility for the individuals in each age group in line 1a during the reporting year.

Line 3b - Average Period of Eligibility -- Divide line 3a by the number in line 1b. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remain Medicaid eligible during the reporting year.

Line 4 - Expected Number of Screenings per Eligible -- Multiply line 2c by line 3b. Enter the product. This number reflects the expected number of initial or periodic screenings per child per year based on the number required by the State-specific periodicity schedule and the average period of eligibility. **Make no entries in the total column.**

Line 5 - Expected Number of Screenings -- Multiply line 4 by line 1b. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1a.

Line 6 - Total Screens Received - Enter the total number of initial or periodic screens furnished to eligible individuals under either fee-for-service or managed care arrangements.

Note: States may use the CPT codes listed below as a proxy for reporting these screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.

This number should not reflect sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal State periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) Use data reflecting **date of service** within the fiscal year for such screening services or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services *
99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)

99393 Established patient (ages 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant
99463 Initial hospital or birthing center care of normal newborn infant (admitted/ discharged same date)

*These CPT codes do not require use of a "V" code.

or

CPT-4 codes: Evaluation and Management Codes **
99202-99205 New Patient
99213-99215 Established Patient

****** These CPT-4 codes must be used in conjunction with codes V20-V20.2, V20.31 and V20.32 and/or V70.0 and/or V70.3-70.9.

Line 7 - Screening Ratio - Divide the actual number of initial and periodic screening services received (line 6) by the expected number of initial and periodic screening services (line 5). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule, prorated by the proportion of the year for which they are Medicaid eligible.

Note: In calculating Line 7, note that Line 6 should not exceed Line 5. The ratio cannot be over 100%.

Line 8 - Total Eligibles Who Should Receive at Least One Initial or Periodic Screen - The number of persons who should receive at least one initial or periodic screen is dependent on each State's periodicity schedule. Use the following calculations:

1. Look at the number entered in line 4 of this form. If that number is greater than 1, use the number 1. If the number in line 4 is less than or equal to 1, use the number in line 4. (This procedure will eliminate situations where more than one visit is expected in any age group in a year.).

2. Multiply the number from calculation 1 above by the number in line 1b of the form. Enter the product on line 8.

Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen - Enter the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year. **Refer to codes in line 6.**

Line 10 - Participant Ratio - Divide line 9 by line 8. Enter the quotient. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

Note: In calculating Line 10, note that Line 9 should not exceed Line 8. The ratio cannot be over 100%.

Line 11 - Total Eligibles Referred for Corrective Treatment - Enter the unduplicated number of individuals, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic screening service, including vision and hearing screenings, were referred for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. This element does not include correction of health problems during the course of a screening examination.

NOTE: For purposes of reporting the information on dental services in Lines 12a – 12g, "unduplicated" means that a child may only be counted once for each line of data. A child may be counted on two or more lines. For example, a child is counted once on line 12a for receiving any dental service, counted again on line 12c for receiving a dental treatment service and, if applicable, counted again on line 12f for receiving an oral health service by a non-dentist. These numbers should reflect services provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State. We refer to "dental services" when referring to services provided by or under the supervision of a dentist. We refer to "oral health services" when the service is not provided by or under the supervision of a dentist.

Line 12a - Total Eligibles Receiving Any Dental Services - Enter the unduplicated number of children receiving at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (CDT codes D0100 - D9999).
Line 12b - Total Eligibles Receiving Preventive Dental Services - Enter the unduplicated number of children receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 -
(CDT codes D1000 - D1999).

Line 12c - Total Eligibles Receiving Dental Treatment Services - Enter the unduplicated number of children receiving at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 - 09999).

Line 12d – Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non-dentist, as defined by HCPCS code D1351 (CDT code D1351).

Line 12e – Total Eligibles Receiving Diagnostic Dental Services – Enter the unduplicated number of children receiving at least one diagnostic dental service by or under the supervision of a dentist, as defined by HCPCS codes D0120 – D0180 (CDT codes D0120 – D0180).

12f – Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- Enter the unduplicated number of children receiving at least one oral health service as defined a HCPCS or CDT code furnished by a licensed provider that is not a dentist. For example, a pediatrician that applies a fluoride varnish or a dental hygienist not under the supervision of a dentist furnishing a prophylaxis. These are only examples and are not intended to limit your reporting. NOTE: Due to the variance in State Practice Acts some States may not have data to report on this line.

12g – Total Eligibles Receiving any Dental or Oral Health Service -- Enter the unduplicated number of children who received a dental service by or under the supervision of a dentist or an oral health service by a non-dentist. A child should only be counted **once** on this line even if the child received a dental service and an oral health service.

Line 13 - Total Eligibles Enrolled in Managed Care - This number is reported for informational purposes only. This number represents all individuals eligible for EPSDT services in your State who are enrolled in any type of managed care arrangement at any time during the reporting year. It includes any capitated arrangements such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager regardless of whether reimbursement is fee-for-service or capitated. Include these individuals in the total number of eligibles on line 1a; include the number of initial or periodic screenings provided to these individuals in lines 6 and 8 for purposes of determining the State's screening and participation rates. The number of individuals referred for corrective treatment and receiving dental services are reflected in lines 11 and 12, respectively.

Line 14 - Total Number of Screening Blood Lead Tests - Enter the total number of screening blood lead tests furnished to eligible individuals under fee-for-service or managed care arrangements. **Follow-up blood tests performed on individuals who have been diagnosed with or are being treated for lead poisoning should** not **be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:**

1) **Count the number of times CPT code 83655 ("lead") for a blood lead test is reported within certain ICD-9-CM codes (see Note below); or**
2) **You may include data collected from use of the HEDIS®[1] measure developed by the National Committee for Quality Assurance to report blood lead screenings if your State had elected to use this performance measure.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5) (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984(.0-.9) (toxic effect of lead and its compounds) or e861.6 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

[1] Health Effectiveness Data and Information Set

F. Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C4-26-05, Baltimore, Maryland 21244-1850.