UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:

Medicaid's Child Health Evaluation and Care (CHEC)

November 2012

As reported in the January 2012 Health Status Update[1], over 60 percent of Utah Medicaid clients are children. Medicaid currently has 167,000 children on its rolls. About half of these children are less than 6 years old.

As required by federal law, Medicaid has a special benefit for children. This benefit, known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), became part of Medicaid in 1967. The purpose of the benefit is to promote healthy child development and ameliorate conditions that disable children. In Utah, this benefit is called Child Health Evaluation and Care (CHEC).

CHEC has three main components:

- Preventive Health Care
- Outreach and Education
- Expanded Services

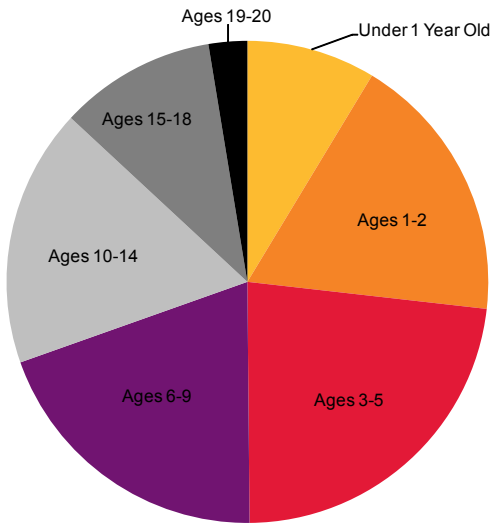
Preventive Health Care is about keeping children healthy. Children who are healthy are more likely to stay healthy and have fewer health costs in the long run. Children who are healthy have fewer missed school days and their parents have fewer missed work days.

Children birth through age 20 on Traditional Medicaid can get CHEC covered services. Medicaid pays for well child visits, which include screening services to detect physical and mental conditions. The CHEC protocols follow recommendations of the American Academy of Pediatrics for the components of the visit as well as recommendations for how often children should receive well-child visits.

- **Medicaid has a special benefit for children called Child Health Evaluation and Care (CHEC) which has three main components:**
- Preventive Health Care is about keeping children healthy.
- Outreach and Education includes efforts to encourage and help families get the recommended well-child care.
- Expanded Services allow Medicaid to pay for medically necessary treatment, equipment or other services that may not be normally covered and are found at the well-child visit.

Medicaid Clients

Figure 1. Number of clients by age group, Ages 0-19, Utah, FY 2011



Source: CMS-416 Report, Federal Fiscal Year 2011

A CHEC well-child visit includes the following components:

- Comprehensive health and developmental history, including an assessment of physical and mental health
- Comprehensive physical examination
- Immunizations, based on the current approved Advisory Committee on Immunization Practices (ACIP) schedule
- Laboratory tests, including mandatory lead screening
- Vision, hearing, and dental services
- Health education and anticipatory guidance

Children may also receive preventive oral health (dental) visits that include an examination and cleaning twice a year, fluoride treatments and sealants.

Outreach and Education includes efforts to encourage and help families get the recommended well-child care. Currently Medicaid provides families information about the CHEC benefit by sending a letter and a brochure when they are first eligible for Medicaid. Families who attend an orientation session also get information about CHEC as part of the description of Medicaid benefits.

Medicaid works in partnership with local public health departments to notify families when children are past due for a well-child or dental exam. The local health department staff contacts these families and encourages them to schedule the preventive visit. These families may also receive a letter reminding them to set up an appointment. The local public health departments also work to develop relationships with local health care

providers to encourage them to see children for well-child and dental exams.

Expanded Services allow Medicaid to pay for medically necessary treatment, equipment or other services that that may not be normally covered when the doctor finds problems at the well-child visit.

Reporting – The federal Medicaid agency, the Centers for Medicare and Medicaid Services (CMS), requires all states to regularly report on the following measures:

- the percent of children who get at least one well child visit each year
- the number of children referred for follow-up care
- the number of children who receive oral health services
- the number of children who receive blood lead level screens.

The target for well-child visits is that 80 percent of children continuously enrolled in Medicaid for 90 days, should receive at least one well child visit. Utah exceeded the target for children less than one year of age and was close for children 1-2 years old. However, older children were less likely to have a well-child visit. Even fewer children received oral health care during the year.

Increasing the Use of Preventive Care

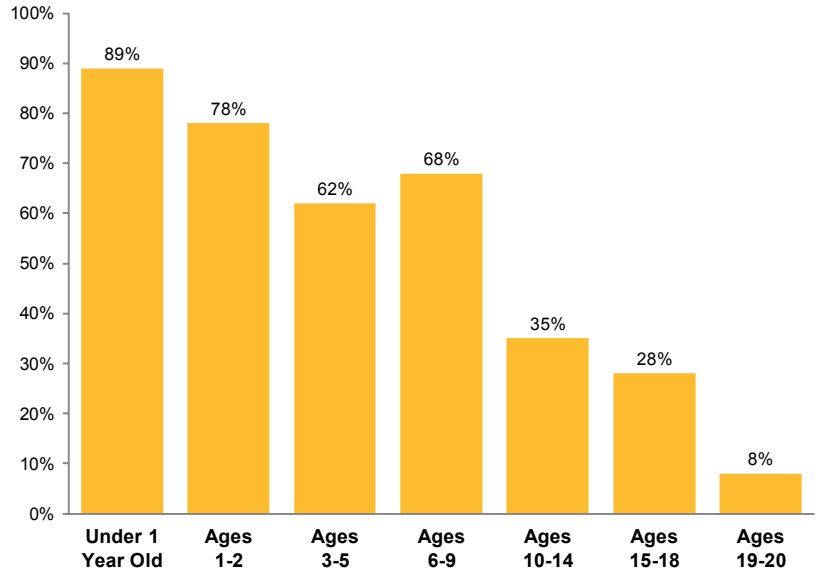
Although state budget cuts in previous years have limited the amount of funding Medicaid has available to spend on CHEC outreach, Medicaid is in the process of revising the CHEC materials given to families when they first become eligible for Medicaid. The revision changes the focus from targeting families who miss well-child visits, to informing and encouraging families before the visit. The goal is to streamline materials to make sure families understand that preventive health care is important, encourage them to get preventive services for their children and offer assistance to schedule the visits. In addition, the outreach staff in the local public health departments is working to increase their interaction with local community groups to better reach and inform families of Medicaid enrolled children.

References

1. The January 2012 Health Status Update is available online at http://health.utah.gov/opha/publications/hsu/1201_MedServe.pdf.

Well Child Visits

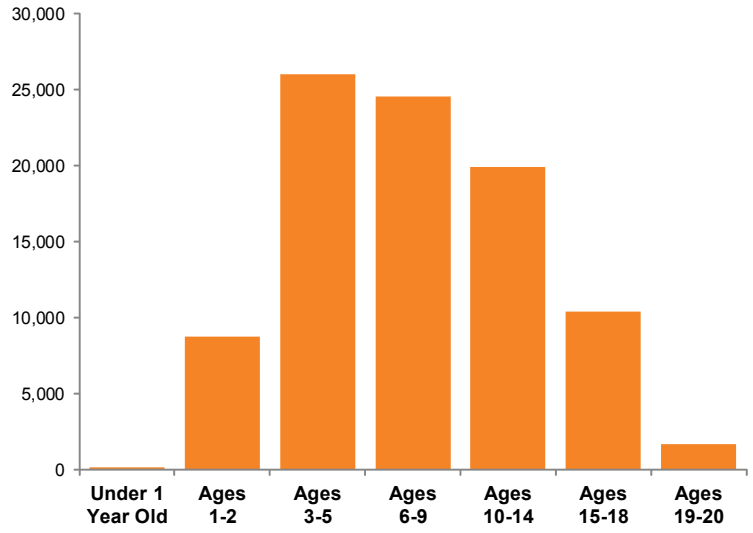
Figure 2. Percentage of children with at least one well child visit by age group, Ages 0-19, Utah, FY 2011



Source: CMS-416 Report, Federal Fiscal Year 2011

Oral Health Care

Figure 3. Number of children receiving any oral health care, Ages 0-19, Utah, FY 2011



Source: CMS-416 Report, Federal Fiscal Year 2011

November 2012 Utah Health Status Update

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Breaking News, November 2012

Evidence-Based Public Health Practice

Evidence-based public health practice is the conscientious, explicit and judicious use of the current best evidence in making decisions in routine public health practice, and in developing public health policies and programs. The use of evidence-based practices promises to provide the best outcomes for populations because the interventions are based on current studies that show repeated, cause-and-effect relationships between the intervention and the desired outcomes.

One example of evidence-based public health is the Chronic Disease Self-Management Program (CDSMP), an education program for people with chronic health problems. The program specifically addresses arthritis, diabetes, lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. It was developed at the Stanford University Patient Education Research Center. Small in-person classes are led by 2 trained leaders following a structured protocol. Class discussions focus on health behaviors and generic disease management skills that are designed to increase participant's self-efficacy. What is the 'evidence' for CDSMP? Repeated studies have shown that participants who participate in the CDSMP demonstrated improvements in a number of desired outcomes that included exercise; ability to do social and household activities; less depression, fear and frustration or worry about their health; reduction in symptoms like pain; and increased confidence in their ability to manage their condition.

The population of older Americans with accompanying chronic illnesses is rapidly increasing. Effective community-based self-management programs will help older adults manage their chronic conditions effectively. For these reasons, a number of chronic disease-related programs in the Utah Department of Health, Bureau of Health Promotion endorse the CDSMP.

For more information about evidence-based public health practice please see *The Community Guide to Preventive Services*: http://www.thecommunityguide.org/index.html; and the Utah Arthritis Program: http://health.utah.gov/arthritis/.

Community Health Indicators Spotlight, November 2012

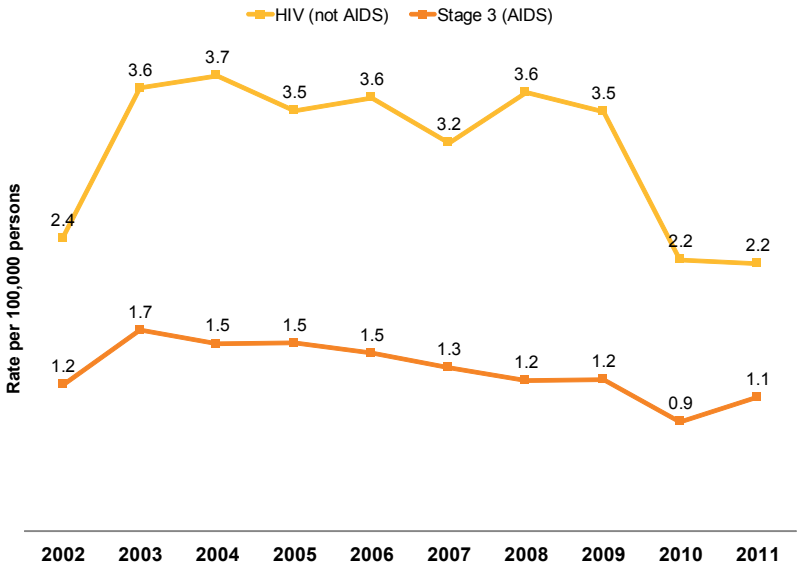
Utah's interaction with National HIV/AIDS Strategy

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

Vision statement
National HIV/AIDS Strategy

The National HIV/AIDS Strategy (NHAS) focuses on reducing new HIV infections, increasing access to care and improving health outcomes for people living with HIV and reducing HIV-related disparities and health inequities. The core components of the strategy are: HIV Testing, Comprehensive Prevention with Positives, Condom Distribution and Policy Initiatives.

HIV/AIDS Infection Rates, Utah, 2002-2011



The Communicable Disease Prevention Program (CDPP) took an early proactive approach to realign its programming to match the goals of the strategy before its mandated implementation in 2012. In addition, the CDPP increased its collaboration efforts with federal, state, tribal and local partners.

The CDPP's efforts and those of its local partners have been crucial in reducing the number of new infections in Utah. In addition, the CDPP's participation with federal partners has been pivotal in the organizing of the first Regional HIV/AIDS Summit in June of 2012.

Monthly Health Indicators Report

(Data Through September 2012)

Monthly Report of Notifiable Diseases, September 2012	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	45	27	381	310	1.2
Shiga toxin-producing Escherichia coli (E. coli)	8	13	91	101	0.9
Hepatitis A (infectious hepatitis)	0	1	4	7	0.6
Hepatitis B, acute infections (serum hepatitis)	0	1	11	8	1.4
Meningococcal Disease	0	1	3	7	0.5
Pertussis (Whooping Cough)	30	28	935	255	3.7
Salmonellosis (Salmonella)	15	34	197	265	0.7
Shigellosis (Shigella)	7	5	25	33	0.8
Varicella (Chickenpox)	12	41	208	430	0.5
West Nile (Human Cases)	2	8	4	20	0.2
Quarterly Report of Notifiable Diseases, 3rd Qtr 2012	**Current Quarter # Cases**	**Current Quarter # Expected Cases (5-yr average)**	**# Cases YTD**	**# Expected YTD (5-yr average)**	**YTD Standard Morbidity Ratio (obs/exp)**
HIV/AIDS†	8	25	67	82	0.8
Chlamydia	2,038	1,604	5,773	4,739	1.2
Gonorrhea	138	112	326	341	1.0
Syphilis	14	8	23	25	0.9
Tuberculosis	11	5	31	23	1.3
Medicaid Expenditures (in Millions) for the Month of September 2012	**Current Month**	**Expected/ Budgeted‡ for Month**	**Fiscal YTD**	**Budgeted‡ Fiscal YTD**	**Variance - over (under) budget**
Capitated Mental Health	$ 18.2	$ 4.8	$ 38.2	$ 24.2	$ 14.1
Inpatient Hospital	$ 16.5	$ 15.3	$ 41.2	$ 60.6	$ (19.3)
Outpatient Hospital	$ 7.3	$ 8.0	$ 16.0	$ 22.0	$ (5.9)
Long Term Care	$ 14.6	$ 13.0	$ 35.6	$ 35.2	$ 0.4
Pharmacy§	$ 16.7	$ 10.8	$ 42.1	$ 29.6	$ 12.5
Physician/Osteo Services	$ 9.6	$ 7.7	$ 20.3	$ 21.1	$ (0.8)
TOTAL HCF MEDICAID	$185.6	$ 154.2	$ 379.7	$ 385.0	$ (5.3)

Program Enrollment for the Month of September 2012	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	253,052	253,188	-0.1%	245,970	+2.9%
PCN (Primary Care Network)	15,515	15,919	-2.5%	15,336	+1.2%
CHIP (Children's Health Ins. Plan)	36,045	36,232	-0.5%	37,535	-4.0%
	Annual Visits			Annual Charges	
Health Care System Measures	**Number of Events**	**Rate per 100 Population**	**% Change¶ From Previous Year**	**Total Charges in Millions**	**% Change¶ From Previous Year**
Overall Hospitalizations (2010)	274,576	9.0%	-2.6%	$ 5,416.2	+5.9%
Non-maternity Hospitalizations (2010)	167,340	5.3%	-0.9%	$ 4,552.5	+5.9%
ED Encounters - Not Admitted (2010)	645,962	21.5%	-7.7%	$ 1,160.9	+7.4%
Outpatient Surgery (2009)	311,442	10.6%	+1.9%	$ 1,465.7	+14.7%
Annual Community Health Measures	**Current Data Year**	**Number Affected**	**Percent/ Rate**	**% Change¶ From Previous Year**	**State Rank# (1 is best)**
Obesity (Adults 18+)	2011	472,400	24.4%	+1.3%	12 (2011)
Cigarette Smoking (Adults 18+)	2011	229,300	11.8%	+2.7%	1 (2011)
Influenza Immunization (Adults 65+)	2011	147,400	56.9%	-15.5%	41 (2011)
Health Insurance Coverage (Uninsured)	2010	301,900	10.6%	-5.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2010	231	8.1 / 100,000	+0.1%	19 (2009)
Poisoning Deaths	2010	342	12.0 / 100,000	-38.1%	47 (2009)
Suicide Deaths	2010	479	16.8 / 100,000	+5.8%	n/a
Diabetes Prevalence (Adults 18+)	2011	129,600	6.7%	-1.8%	6 (2011)
Poor Mental Health (Adults 18+)	2011	315,300	16.3%	-0.4%	17 (2011)
Coronary Heart Disease Deaths	2010	1,488	52.2 / 100,000	-0.4%	2 (2008)
All Cancer Deaths	2010	2,791	98.0 / 100,000	+7.9%	1 (2008)
Stroke Deaths	2010	736	25.8 / 100,000	-1.4%	13 (2008)
Births to Adolescents (Ages 15-17)	2010	876	14.3 / 1,000	-13.2%	17 (2009)
Early Prenatal Care	2010	38,124	73.1%	+2.1%	n/a
Infant Mortality	2010	251	4.8 / 1,000	-9.0%	3 (2008)
Childhood Immunization (4:3:1:3:3:1)	2010	38,900	70.6%	-7.8%	12 (2010)

Note: Active surveillance has ended for influenza virus until the 2012-2013 season.
† Diagnosed HIV infections, regardless of AIDS diagnosis.
‡ Budget has been revised to include supplemental funding from 2011 General Session.
§ Only includes the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part-D amounts are excluded from this line item.
¶ % Change could be due to random variation.
# State rank based on age-adjusted rates.
Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile virus has ended until the 2012 season.