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## ***CMCS Informational Bulletin***

**DATE:** November 30, 2016

**FROM:** Vikki Wachino, Director  
Center for Medicaid and CHIP Services

**SUBJECT:** **Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children’s Health Insurance Program**

### **Background**

The recent water crisis in Flint, Michigan, serves as a reminder of the importance of blood lead screening for children. While substantial environmental improvements have been made to reduce exposure to lead, over four million children are estimated to reside in housing where they are exposed to lead.<sup>1</sup> The Centers for Disease Control and Prevention (CDC) projects that there are about half a million children between the ages of one and five years in the United States who possess blood lead levels greater than 5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ), which is the threshold level at which CDC recommends public health actions are taken.<sup>2</sup> It is essential that children enrolled in the Medicaid and Children’s Health Insurance Program (CHIP) receive blood lead screening tests as required in order to identify children with elevated blood lead levels (EBLLs) at as young an age as possible. The goal of lead screening is to assist children before they are harmed. Comprehensive screening and surveillance ensures that lead-poisoned infants and children receive medical and environmental follow-up as soon as possible and allows for the development of neighborhood-based efforts to prevent lead poisoning.<sup>3</sup> Lead exposure can impact nearly every system in the body and often goes undetected because at low levels of exposure, it can occur without any obvious symptoms.<sup>4</sup> Exposure to lead can cause damage to the brain and nervous system, slowed growth and development, learning and behavior problems, and hearing and speech problems. While lead paint has historically been the greatest source of exposure to lead, children can be exposed to lead from additional sources (such as lead smelters, leaded pipes, solder and plumbing fixtures, and consumer products) and through different pathways (such as air, food, water, dust and soil).<sup>5</sup>

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<sup>1</sup> Lead. (2016, January 29). Retrieved from <http://www.cdc.gov/nceh/lead/>

<sup>2</sup> Lead. (2016, January 29). Retrieved from <http://www.cdc.gov/nceh/lead/>. In 2012, the reference level to identify children with blood lead levels that are much higher than most children’s levels was changed to 5  $\mu\text{g}/\text{dL}$ .

<sup>33</sup> Lead – CDC’s Childhood Lead Poisoning Prevention Program. (2015, February 9). Retrieved from <http://www.cdc.gov/nceh/lead/about/program.htm>

<sup>4</sup> Lead. (2016, January 29). Retrieved from <http://www.cdc.gov/nceh/lead/>

<sup>5</sup> Lead (2015, May 29). Retrieved from <http://www.cdc.gov/nceh/lead/tips/sources.htm>

Ensuring that all children enrolled in Medicaid and CHIP receive blood lead screening tests as required involves a commitment and action by state Medicaid and CHIP agencies as well as partnerships between these state agencies, health care providers and other state agencies, such as health departments and lead poisoning prevention programs. This Informational Bulletin provides an overview of the screening requirements for children enrolled in Medicaid and CHIP and also identifies steps that states can take to improve lead screening efforts in order to reach children at risk of EBLs.

## **Coverage of Lead Screening**

### Medicaid

All children enrolled in Medicaid, regardless of whether coverage is funded through title XIX or XXI, are required to receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between ages 24 and 72 months with no record of a previous blood lead screening test must receive one.<sup>6</sup> Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted.

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid provides comprehensive coverage, for any service described in section 1905(a) of the Social Security Act needed that is medically necessary to correct or ameliorate defects in physical and mental illnesses or conditions identified by the screening services, whether or not such service is otherwise covered under the state plan. Medicaid also provides reimbursement for lead investigations in the home or primary residence of a child with an EBL. Any lead investigation must be conducted by a credentialed health practitioner who meets the qualifications established by the state and is undertaken to identify the source of lead exposure.<sup>7</sup> States have an affirmative obligation to ensure that Medicaid-eligible children and their families are aware of the services that are a part of the EPSDT benefit and have access to required screenings and necessary treatment services.<sup>8</sup>

It is not necessary to refer a child to a separate laboratory facility for a blood lead screening test, Medicaid will pay for a blood sample drawn in the physician's office using a point of service blood lead screening test. However, there is concern that not all blood lead screening tests conducted in provider's offices are coded in a way to be included in Medicaid screening data. States should provide clear guidance to providers on these data and reporting requirements to ensure that results are coded correctly and reported to state health departments for inclusion in state lead screening surveillance data.

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<sup>6</sup> Medicaid Manual section 5123.2.D.1.

<sup>7</sup> Medicaid Manual section 5123.2.D.1.a

<sup>8</sup> Section 1902(a)(43)(A) of the Social Security Act (the Act) and Medicaid Manual section 5010

<sup>8</sup> <http://www.cdc.gov/nceh/lead/policy>"

In 2012, the Centers for Medicare & Medicaid Services (CMS) expanded its lead screening policy to allow states to request approval from CMS to implement a targeted lead screening program.<sup>9</sup> This change was made to align the Medicaid lead screening policy with that of the CDC, recognizing that risk of exposure to lead in some states may not be evenly spread throughout the state, and to allow states' resources to be used more efficiently for children most at risk.

States that wish to implement a targeted lead screening plan need to work closely with their state health departments to determine an appropriate targeting methodology for the state. State proposals need to include information such as the areas of local risk for elevated blood lead levels, information on current estimates of blood lead screening rates by local jurisdiction and risk status, and a proposed blood lead screening strategy that will focus available resources on the population at highest risk. CMS provided detailed guidance on how states can develop and submit proposals through two CMCS Informational Bulletins (CIBs) issued on March 30, 2012, and June 22, 2012. Both of these CIBs, as well as a *Guide For States Interested in Transitioning to Targeted Blood Lead Screening for Medicaid-Eligible Children*, are available on Medicaid.gov.<sup>10</sup> All submitted proposals are jointly reviewed by CMS and CDC. To date, Arizona is the only state that has an approved targeted lead screening policy.

### CHIP

Separate CHIP programs do not have the same requirements for universal lead screening as Medicaid, although we encourage states to align their CHIP and Medicaid screening policies. States are required to offer well-child visits,<sup>11</sup> and must select a periodicity schedule. States commonly use the Bright Futures periodicity schedule (developed by the American Academy of Pediatrics), which recommends blood lead screening tests at 12 months and 24 months for children at risk of lead exposure or in high prevalence areas.<sup>12</sup> States that offer EPSDT benefits through their separate CHIP should follow Medicaid's universal screening policy.

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<sup>9</sup> The March 30, 2012, and June 22, 2012, CIBs are available on Medicaid.gov through these links: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-30-12.pdf> and <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-22-12.pdf>. The guidance document is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/targetedleadscreening.pdf>.

<sup>10</sup> The March 30, 2012, and June 22, 2012, CIBs are available on Medicaid.gov through these links: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-30-12.pdf> and <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-22-12.pdf>. The guidance document is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/targetedleadscreening.pdf>.

<sup>11</sup> 42 CFR 457.10(b)

<sup>12</sup> Bright Futures/American Academy of Pediatrics. Updated 10/2015. Recommendations for Preventive Pediatric Health Care - footnotes 19 and 20.

### **Data and Data Reporting to CMS**

Medicaid agencies are required to submit EPSDT data annually using the Form CMS-416<sup>13</sup>, including the number of blood lead screening tests for children enrolled in Medicaid, from birth to age 6, regardless of whether they are funded through title XIX or XXI. According to data reported on Form CMS-416, the number of children enrolled in Medicaid who receive blood lead screening tests varies considerably from state to state. When the number of blood lead screening tests reported for 2015 on the Form CMS-416 are compared to the number of children that are eligible for EPSDT and continuously enrolled in Medicaid for at least 90 days, the data suggests that only about 38 percent of children ages 1 – 2 are reported to have been screened. CMS believes that this underrepresents the actual number of children who received blood lead screening tests because the CMS-416 captures claims and encounter based data; the form does not capture screenings that are not paid for by Medicaid, such as screenings performed by clinics using CDC funding or funded by state health departments. However, the data does indicate that there are many children at risk of lead exposure that are not being tested.

The [instructions for the Form CMS-416](#) require states to report data that includes services reimbursed directly by the state – this requirement applies regardless of whether the reimbursement happens under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health plans that contract with the state. States are required to collect encounter data (or other data as necessary) from managed care and prospective payment entities in sufficient detail to provide the information required by the report.<sup>14</sup>

Specific to the blood lead screening line (line 14) on the Form CMS-416, states may use one of two methods, or a combination of these methods, to calculate the number of blood lead screening tests provided:

1. Count the number of times Current Procedural Terminology (CPT) code 83655 (“lead”) for a blood lead screening test is reported within certain ICD-10-CM codes; or
2. Include data collected from use of the Healthcare Effectiveness Data and Information Set (HEDIS) blood lead screening measure developed by the National Committee for Quality Assurance (NCQA) to report blood lead screening tests, if your state has elected to use this performance measure.<sup>15</sup>

It is essential that the data submitted using the Form CMS-416 is accurate, and we request that states review their data carefully prior to submission. As CMS and states begin to use the Transformed Medicaid Statistical Information System (T-MSIS), we expect that CMS will be

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<sup>13</sup> The CMS-416 form and instructions can be accessed through the EPSDT page on Medicaid.gov: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. State reported data is also available through this link.

<sup>14</sup> Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report. Version 3, as of November 17, 2014; page 1. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-416-instructions.pdf>

<sup>15</sup> Instructions for Completing Form CMS-416; Version 3; page 11.

able gather more timely and accurate estimates of blood lead screening rates than what is currently indicated by the Form CMS-416.

As referenced above, NCQA has a HEDIS quality measure for blood lead testing of 2-year-old children continuously enrolled in Medicaid for eleven months. NCQA has reported, on average, a blood lead screening rate of 66 percent for Medicaid managed care plans that reported on this measure over the last 2 years. Using and reporting on this measure is optional, with approximately 30 states reporting, so it is not representative of the entire country.<sup>16</sup> However, it does provide another data source and an opportunity to evaluate Medicaid managed care plans that report on this measure. Data from this measure can be used for annual Form CMS-416 reporting.

### **State Action**

There are a number of actions that we encourage states to undertake in order to improve blood lead screening rates and reporting:

- Review your state’s most recent [Form CMS-416](#) data submission and any other available data sources (including CDC surveillance data) to understand your state’s blood lead screening rate and to determine areas for improvement of data submission and to identify inconsistencies in rates of blood lead screening tests, as well as any data reporting errors that might exist. If an error in reporting on the Form CMS-416 is identified, corrected data should be submitted to CMS. When reviewing your state’s data submitted on the Form CMS-416, please ensure that the data submitted includes all delivery systems, as specified in the CMS-416 instructions.
- Review all coverage materials, manuals, periodicity schedules, and your state’s website to ensure that information on lead screening is clearly written and consistent with Medicaid and CHIP requirements. Also review information on lead screening distributed by your Department of Health, and ensure that there is consistent messaging across state agencies. Documents that should be reviewed include provider materials/manuals, managed care contracts, and educational materials for beneficiaries and their families. Consider sharing sample materials with a group of Medicaid and CHIP providers and beneficiaries prior to release to ensure that the messaging is clear and understandable.
- Collaborate with your state’s health department and lead poisoning and prevention program to reach children who have not received required blood lead screening tests. Collaboration could include combined outreach to families and data sharing agreements between agencies.

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<sup>16</sup> Lead Screening in Children. NCQA. <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/lead-screening>

- Partner with providers, such as pediatricians, family physicians, and other experts in pediatric health care to ensure that children enrolled in Medicaid or CHIP receive required blood lead screening tests. Provide clear information on the Medicaid and CHIP lead screening requirements to providers; ensure that they understand these requirements; and request that any materials prepared by the provider also include clear language and guidance to patients. We encourage states to align their CHIP and Medicaid screening policies.
  
- Require managed care plans to engage in your efforts to improve blood lead screening rates. With over two-thirds of children enrolled in Medicaid and CHIP covered under managed care, managed care plans have an important role to play in improving lead screening. States are encouraged to consider using the following managed care tools to effectively partner with managed care plans to improve blood lead screening tests:
  - **Contracts:** Include lead screening requirements in managed care contracts in order to emphasize its importance and ensure that additional monitoring occurs through the annual state report required by 42 CFR 438.66.
  - **Data Reporting and Quality Measures:** As mentioned above, the HEDIS Medicaid-only lead screening quality measure assesses the percentage of children enrolled in Medicaid for 11 continuous months with one or more blood tests for lead poisoning by their second birthday. CMS encourages states to require managed care plans participating in their state Medicaid programs to use this important plan-level quality measure. While the HEDIS measure is Medicaid-specific, CHIP agencies could consider a HEDIS-like measure to monitor screening of children enrolled in CHIP managed care.
  - **Performance Improvement:** Using HEDIS or other performance information, states should compare plan level performance and consider requiring managed care plans to implement performance improvement projects (PIPs) focusing on blood lead screenings. In addition, managed care plans can provide incentives related to increased screening rates.
  - **Quality Assessment and Performance Improvement Programs (QAPI) Managed Care Quality Strategy:** Include screening improvements as one of the quality metrics required by the state for managed care plans under QAPI (42 CFR 438.330(c) and 457.1240(b)) and reflect this requirement in the state managed care quality strategy required by 42 CFR 438.340 and 457.1240(e).
  
- Consider developing a state-designed Health Services Initiative (HSI) to increase blood lead screening rates for young children. HSIs are available under title XXI to improve the health of low-income children,<sup>17</sup> including children enrolled in Medicaid and CHIP, and can include both direct services and public health initiatives. Claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of title XXI funds

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<sup>17</sup> HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in the regulations at 42 CFR 457.10

claimed by the state each quarter.<sup>18</sup> Within the 10 percent limit, states must fund costs associated with administration of the CHIP state plan first; any funds left over may be used for an HSI.

- Missouri currently has an approved HSI to improve lead screening rates. Through a Memorandum of Agreement with the Missouri Department of Health & Senior Services, the State provides funding annually for local public health departments to provide blood lead screenings tests as well as outreach and education to children in areas that are designated as warranting higher vigilance in testing children for elevated blood lead levels. The state follows the EPSDT guidelines for testing. In addition, Missouri has a managed care incentive for lead screening.
- Leverage partnerships with nontraditional providers within your network. For example, Women, Infant and Children (WIC) clinics, local health clinics, Federally Qualified Health Centers, and school-based health centers provide blood lead screening tests within the scope of their services. If you already recognize these clinics as providers, encourage these providers to administer blood lead screening tests while Medicaid and CHIP children are visiting these clinics for other services. This reduces the number of missed opportunities for a child to receive a required blood lead screening test and allows your state to capture lead screening data, as it will be included in your claims/encounter data. In addition, consider partnering with your state's child care licensing entity to distribute information about blood lead screening tests.

As lead abatement plays a significant role in reducing lead exposure for children, collaboration with state housing departments is also recommended. It is important to note that accurate state data on the prevalence of elevated blood lead levels is necessary to apply to lead abatement grant programs.

It is expected that as the blood lead screening rates for children enrolled in Medicaid and CHIP increase, the number of children who are identified as having EBLLs will also increase. States need to think beyond screening, and ensure that guidance and resources are available and in place to support providers, families and other stakeholders who work to obtain appropriate services for children with EBLLs. In addition, improved blood lead screening data will assist cities and states as they apply for grant funding related to primary prevention of lead exposure, such as grants from the Department of Housing and Urban Development.

As stated earlier, the EPSDT benefit includes coverage of any medically necessary medical service to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. In addition, case management can be used to provide services

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<sup>18</sup> Per section 2105(a)(1)(D), HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter.

to children with EBLs.<sup>19</sup> Case management benefits include services that assist eligible individuals gain access to needed medical, social, educational, and other services. They must include all of the following: comprehensive assessment of an eligible individual; development of a specific care plan; referral to needed services; and monitoring activities. Under this benefit, states may target case management services to a specific group of individuals or to individuals who reside in specified areas of the state (or both).

CMS is committed to working with states to improve blood lead screening rates for children enrolled in Medicaid and CHIP, and is available to provide technical assistance. For further information, please contact Karen Matsuoka, PhD, CMCS Chief Quality Officer and Director, Division of Quality and Health Outcomes, at [karen.matsuoka@cms.hhs.gov](mailto:karen.matsuoka@cms.hhs.gov) or 410-786-9726.

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<sup>19</sup> Case management services are defined at 42 CFR 440.169 and 42 CFR 441.18.