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**MEDICAID MANAGED CARE CONTRACTING  
FOR CHILDHOOD LEAD POISONING PREVENTION SERVICES**

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**PREPARED WITH THE SUPPORT OF  
THE CENTERS FOR DISEASE CONTROL AND PREVENTION**

## INTRODUCTION

This study reports on provisions relating to childhood lead poisoning prevention services in Medicaid managed care contract documents (service agreements and requests for proposals, RFPS). The provisions were extracted from the managed care contracts data base of the Center for Health Policy Research of the George Washington University Medical Center. The data base was constructed and is updated as part of the Center's ongoing analytic studies.<sup>1</sup> As with other Center studies of the contract documents, this is a descriptive study of how state Medicaid agencies addressed a series of contracting issues at a specific point in time.<sup>2</sup>

In brief, we found that a substantial number of the 42 contract documents in the data base addressed screening enrolled children for elevated blood lead levels (EBLLS) as a duty of managed care organizations (MCOs) serving Medicaid beneficiaries. However, very few documents addressed either medical followup for children for whom screening showed EBLL or integration of medical followup with public health agency activities to identify and reduce lead hazards in the homes of enrollees with EBLL. This last finding is consistent with a major finding of our larger studies, that at the time the contract documents we analyzed were drafted, state Medicaid agencies were just beginning to consider interactions between MCOs enrolling Medicaid beneficiaries and other public agencies with health-related duties toward enrollees.

We also found that the contract documents rarely identified lead-related services in either quality assurance or as a specific MCO reporting duty. Thus, while managed care is viewed as a means of providing medical homes for Medicaid children and creating administrative systems for tracking and assuring provision of care, the contract documents suggest that many states have yet to really grasp the potential of managed care to provide a tool for improving the quality of lead-related treatment services.

After setting out our methods, findings and discussion of findings, we provide the contract language excerpts on which the analysis is based.

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1 S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, Center for Health Policy Research, The George Washington University Medical Center (First Edition, 1997; Second Edition, 1998).

2. This report was completed August 31, 1998 and has been updated to include current Health Care Financing Administration policy on lead poisoning, as set out in revisions to the *HCFA State Medicaid Manual*.

## A. METHODS

*Negotiating the New Health System* is a descriptive, point in time study of Medicaid managed care contracts, prepared from the Center's unique contracts data base. The data base consists of provisions extracted from 42 comprehensive medical services contracts (service agreements or requests for proposals (RFPs)) for Medicaid managed care services, in effect as of the beginning of 1997.<sup>3</sup> A group of attorneys and health services researchers constructed the data base by a) developing a review instrument reflecting all major domains that are typically addressed in such contract documents; b) reading the contract documents against the instrument to identify contract language addressing the questions in the review instrument; c) entering the language into the data base; and d) sorting the excerpts by domains, topics within domains, and by states. State Medicaid agencies were asked to review the resulting data in draft form to make any necessary corrections or additions.<sup>4</sup>

The review instrument for the project, which was reviewed by a multi-disciplinary advisory group is designed to determine whether a contract document identifies a particular topic and if so, how it addresses the topic. The study allows for a direct comparison of state approaches to all aspects of Medicaid-serving managed care systems. The function of the data base is to permit analysts to (a) identify the topics that states elect to address specifically and (b) understand the manner in which states address them.

For this study, we extracted all provisions from the data base that included the word "lead" and sorted the provisions into four domains: Benefits and Service Duties; Quality Assurance and Performance Measures; Data Collection and Reporting (which includes submission of samples for blood lead testing to state public health laboratories); and Relationships with Public Health Agencies. The four domains reflect the nature of the contract provisions addressing childhood lead poisoning prevention services that we found. For example, while the overall study includes a domain dedicated to provider network competency and capabilities, we did not find language specifically addressing this domain. Thus, there are no extractions to report in this area.

Lead screening is a required element of the Medicaid Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)<sup>5</sup> benefit for children. Certain states elected to incorporate state or federal EPSDT laws, regulations, Medicaid provider manuals or other guidance into their Medicaid managed care contracts, without specifically identifying the

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3 The data base contains an additional 12 "carve-out" contract documents related to mental health or behavioral health services.

4 The data base identifies regulations, statutes, Medicaid provider manuals and other materials incorporated by reference into the contracts but does not present them.

5 42 U.S.C. §1396(r).

individual elements of this benefit, including lead screening. Because our search was limited to provisions that included the word "lead", we do not report on this drafting strategy. Thus, to some extent the study may understate the number of Medicaid managed care contract documents that actually require an MCO to furnish lead-related services for enrolled beneficiaries. Under contract law, materials incorporated into an agreement are legally enforceable, but unless a Medicaid contract clearly requires the MCO to meet all applicable standards under federal law, a general reference to EPSDT may be sufficiently ambiguous that no or limited lead-related duties are created.<sup>6</sup>

This caveat about findings on benefits and service duties does not apply to the domains of quality assurance, reporting and relationships between MCOs and public health agencies. Since these domains do not rest on external federal legal requirements, there is no broader, compensatory legal duty that substitutes for the omission of an express lead-related duty.<sup>7</sup>

Certain provisions fall into more than one domain. For example, a quality assurance provision may also contain reporting requirements. In the excerpts section, we show such language in both domains.

## B. FINDINGS AND ANALYSIS

*Benefits and Service Duties:* Twenty of the 42 contract documents in the data base contain language addressing MCO duties relating to lead-related care. Generally, this language was limited to screening. Fifteen of the 20 contracts specifically required screening enrolled children by means of blood lead laboratory tests or "blood lead levels," which we read to mean laboratory tests. One contract, Tennessee, required prenatal lead screening.

Certain states required the screenings in accordance with the "EPSDT periodicity schedule." A few set out the children's ages or frequency with which screening services were to

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6 Ambiguities in an contract would generally be construed against the Medicaid agency as the drafter of the contract with the result that the agency may remain financially liable for lead-related services that it intended the Contractor to cover. Ambiguities could arise from the drafting of the EPSDT contract language; from general rules of construction included in the contract; from the contractor's discretionary authority under the contract to determine the "medical necessity" of covered services; or other factors.

7 State public health statutes and regulations that treat diagnosis of elevated blood lead levels as a notifiable event typically create reporting duties for health care professionals and laboratories but not MCOs. However, a managed care contract can create a duty for the MCO to assure adherence to such reporting duties by its participating providers and laboratories.

be furnished.<sup>8</sup> Five of the 20 simply specified lead levels (or screening) for enrollees under age 21; three (Massachusetts, Missouri, and Utah) required such services at age 6 months through 72 months; one (New Hampshire) also required screening for children younger than 6 months "when medically necessary." One contract (Massachusetts) contained detailed requirements for verbal risk assessments and the use of such assessments in determining frequency of tests (and other services).

"...A child's level of risk for exposure to lead depends upon the answers to the above questions

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<sup>8</sup>The data on which our study was based predates the 1998 Health Care Financing Administration (HCFA) clarification of federal Medicaid policy on lead-related services, which is set out below.

**Lead Toxicity Screening.** -- all children are considered at risk and must be screened for lead poisoning. HCFA requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

At this time, states may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.

a. **Diagnosis, Treatment, and Follow-Up.** -- If a child is found to have blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated. Determining the source of lead may be reimbursable by Medicaid under certain circumstances. Reimbursement is limited to a health professional's time and activities during an on-site investigation of a child's home (or primary residence). The child must be diagnosed as having an elevated blood lead level. Medicaid reimbursement is not available for any testing of substances (water, paint, etc.) which are sent to a laboratory for analysis.

b. **Coordination With Other Agencies.** -- Coordination with WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. *HCFS, State Medicaid Manual §5132.2D* (revised effective April 16, 1998).

In a letter notifying State Medicaid Directors of this clarification, HCFA also indicated that the screening schedule set out above is a *minimum* standard and that children may receive additional screening tests at other times:

Any additional blood lead tests continue to be covered based on a provider's medical judgment, as well as any medically necessary diagnostic and treatment services coverable under Medicaid. Letter of April 13, 1998 from Sally K. Richardson, Director of the Health Care Financing Administration Center for Medicaid and State Operations to state Medicaid directors.

[which are set out in the contract]. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answers to any question is affirmative, a child is considered at high risk for high doses of lead exposure. A child's risk category can change with each administration of the verbal risk assessment....The frequency with which the blood lead test is to be administered depends upon the results of the verbal risk assessment..."

Very few contracts addressed the duty to provide or arrange for the integrated regimen of medical and environmental services without which children's elevated blood lead levels cannot effectively be reduced. Indeed, few even specified the followup diagnostic and treatment services for children with EBLL, which would be appropriate in a medical services contract. None addressed the evidence that would be considered sufficient to establish the medical need for such services, for purposes of coverage determinations, or treatment protocols to be followed. The Massachusetts and Utah contracts offer exceptions to this overall practice.

The fact that the contracts do not specifically address followup medical services does not, of course, mean that they would not be furnished as covered physician, pharmacy, laboratory and other general categories of services. Contract silence, however, confers discretion on the MCO and its providers to determine what will be done following discovery of an EBLL in an enrolled child.

The coordination of medical services (ongoing testing to monitor a child's lead level and necessary treatment) with reduction of lead hazards in the home of a child with EBLL historically has been arranged by state, regional or local health agencies (and childhood lead poisoning prevention programs within those agencies), through multi-disciplinary case management (also known as care coordination) and liaison with environmental and housing agencies. Only one contract, Missouri, addressed multi-disciplinary case management for a child with EBLL, although it does not mention environmental services specifically:

"...HCY [the state's EPSDT program] Case Management can be used to reach out beyond the bounds of the Medicaid program or health plan to coordinate access to a broad range of services, regardless of the source of funding for the services. The services to which access is gained must be found by the health plan to be medically necessary for the child. HCY Case Management services are intended to assist individuals in gaining access to needed medical, social, educational and other services. The health plan may assist the individual in accessing these services.

**Lead Case Management:** Plans must screen children for elevated blood lead levels as part of the requirement for the EPSDT/HCY program. When a child is identified with an elevated blood lead level, the health plan is responsible for providing medically necessary services including case management for the child..."

*Quality Assurance and Performance Measures:* Eleven of the 42 contracts contain language establishing some type of quality or performance standards relating specifically to lead.

Five contract documents (Florida, Kansas, New Jersey, Rhode Island, Texas) identified lead or "lead toxicity" as an optional or mandatory area for an MCO's quality-related activities. Two states (New Jersey and Wisconsin) established performance standards for lead screening. For example, the Wisconsin contract establishes the following "objective":

"...The objective for calendar year 1997 is 50% of all Medicaid enrollees with their first or second birthday during the reporting period (calendar year 1997) who are continuously enrolled for the 12 months prior to their first or second birthday will have had one blood lead test. Two rates must be reported, one for one year Olds and one for two year Olds..."

This measure would, of course, capture rates only of Medicaid enrollees with relatively stable program eligibility and enrollment in the reporting managed care plan.

One state, Rhode Island, requires the MCO to establish an internal tracking system to monitor provision of EPSDT services including, specifically, "Preventive pediatric visits in accordance with" the state's EPSDT periodicity schedule and the state's health department "lead guidelines."

*Data Collection and Reporting.* Ten of the 42 contract documents contain lead-specific reporting specifications. These provisions fall into two broad categories: reporting relating to provision of lead services and reporting relating to public health surveillance. Service-related reporting duties ranged from encounter data reporting (D.C.) to quality assurance data reporting (Texas) and utilization data (Wisconsin). Public health-related reporting including requirements to submit blood lead test samples to state health laboratories in three states (Illinois, Rhode Island and Vermont). Note that the following language from the Vermont contract also obligates the Contractor and its providers to ensure that any out-of-state laboratories with which they do business comply with the state's reporting requirements. As managed care organizations (and their providers) consolidate their laboratory work in organizations serving multiple states, such contract language appears to be the only means of assuring reporting to a state's lead surveillance programs.

"...Contractor shall submit all reference specimens for the confirmation of positive blood lead...It is the responsibility of the Contractor to comply with Vermont disease reporting requirements... The Contractor and/or their participating providers (as applicable) who contract with out-of-state labs, are responsible for ensuring that the lab vendor complies with Vermont's disease reporting requirements..."

*Relationships with Public Health Agencies:* Nine of the 42 contracts address some type of relationship (other than reporting) between the MCO and a public health agency with regard to lead services. A few contracts specifically address the relationship between contract services and public health agency programs (e.g., childhood lead poisoning prevention programs) regarding lead "assessment" or testing services (Missouri, Montana) or services to identify and or reduce lead hazards in the environment of a child enrollee with EBLL (New York, Vermont,



Wisconsin). Where the services furnished by a public health agency to a Contractor's enrollee are medical services the contractor is obligated to reimburse the agency (Montana) or the Medicaid agency pays the agency directly (Missouri). Where the services furnished by the health agency are public health or epidemiological interventions -- i.e., environmental investigations or other "followup services", the services appear to remain the financial responsibility of the health agency.

The contracts addressing provision of epidemiological services may or may not require the MCO to coordinate its medical services with environmental or other followup services furnished by the health agency. Under the New York contract:

"...Health plan PCPs will be responsible for screening, diagnosing and treating children with elevated blood lead levels. Plans/PCPs also must coordinate the care of such children with local health departments to assure appropriate follow-up by the departments in terms of environmental investigation and risk management."

In contrast, the less specific Wisconsin language specifies that:

"The following specific services have been delineated with the hope of linking Medicaid Managed Care Plans with Local Health Departments. Linking primary care and public health is an essential strategy to strengthen the health of local communities and thus benefit the population of the state as a whole...

LHDs provide health-related home/community inspections in areas that include Lead Poisoning."

Other types of MCO-public health agency relationships envisioned by the contacts include provision by the health departments of "recommended medical protocols" for lead screening (e.g., New Hampshire) and, as mentioned above, submission of samples for blood lead testing to state laboratories.

## C. DISCUSSION

Under fee for service Medicaid, the promise of universal lead screening for Medicaid children has not been realized. The General Accounting Office (GAO) reported in February, 1998 reported very low Medicaid lead screening rates in a national sample of children screened between 1991 and 1994, before most states had converted their Medicaid programs to managed care.<sup>9</sup>

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<sup>9</sup>United States General Accounting Office, Medicaid: Elevated Blood Lead Levels in Children

We found that about half the contract documents examined for this study addressed lead-related services for children, primarily screening. Quality assurance standards for these services as well as lead-specific reporting duties are relatively rare, as are provisions addressing relationships between MCOs and agency providers of non-medical services relating to environmental lead. We conclude that at the time the contracts we studied were drafted, only a few states were beginning to realize the enormous potential of Medicaid managed care to improve Medicaid children's access

We suggest that sample purchasing specifications, setting out a full range of drafting options for lead-related services, may assist state Medicaid agencies, public health agencies and managed care organizations in determining the appropriate roles and responsibilities of each entity in reducing elevated blood lead levels in enrolled children.

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(GAO/HEHS-98-78, February, 1998) GAO estimated that one in twelve Medicaid children ages one through five, or about a half a million, had harmful effects of lead in their blood when screened for the National Health and Nutrition Examination survey (NHANES). For nearly two-thirds of these children, the NHANES screening was the first blood lead level test that they had received. While GAO did not explore the reasons so few Medicaid children receive lead screening, the most likely explanations are the difficulties many Medicaid families have had in finding physicians who will accept them into their practices, lack of information for families about the potential for lead poisoning for their children and, possibly, low priority among many physicians for lead screening.

**D. LEAD-RELATED EXTRACTS FROM  
MEDICAID MANAGED CARE CONTRACT DOCUMENTS**

***Benefits and Service Duties***

**"XIII. SERVICE DELIVERY...**

...The following requirements related to the provision of EPSDT services and must be incorporated into the Contractor's preventive health services...

**(1) EPSDT Services...**

The EPSDT examination or health screening consists of:...

f. Laboratory Testing (including lead toxicity screening which must be done according to the state's EPSDT periodicity table)... **Colorado Contract**, pages 7A, 8A.

**"Article 7**

**SERVICE DELIVERY AND QUALITY ASSURANCE  
REQUIREMENTS**

**GENERAL...**

H. Each Provider shall provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (well-child services) in accordance with the D.C. Medicaid State Plan. EPSDT services shall include, but are not limited to, the following:

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1. Notifying the parents of enrolled children under the age of 21 that the children are entitled to an annual examination and evaluation of their general physical and mental health and growth, development and nutritional status, and provide, or arrange for, such examination for the eligible children. The children of those parents who request the examinations shall receive the examination within 30 days of the date of the request. At a minimum these examination must include a comprehensive health and developmental history; a comprehensive unclothed physical examination; vision testing; hearing testing; appropriate laboratory tests (including lead blood levels)... **District of Columbia Contract**, pages 7, 8.

**"6.1.1.2 Screens**

MCOs must provide screenings (periodic comprehensive child health assessments) to all eligible EPSDT recipients who request them. These should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. At a minimum, these screenings must include, but are not limited to:

(g) Blood lead testing..." **Delaware RFP**, pages II.24, II.25.

"a. The health screening examination shall consist of...nutritional assessment...laboratory testing (including lead screening); health education (including anticipatory guidance)..." **Florida Contract**, page 84.

"4.6 Continuing Care Provision (EPSDT) Provide all covered services to eligible Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients formally enrolled with the provider according to the periodicity schedule found in Addendum XI, including: (1) screening, diagnosis, treatment and referral for follow-up... (11) provide lead screening services as specified in the EPSDT periodicity schedule..." **Iowa 1997 Contract**, pages 14-15.

"... Please see the Physician's Service Provider's Manual for the periodicity schedule and additional information regarding screening examinations..." **Iowa 1997 Contract**, Addendum I, pages 59, 60.

"Initial, periodic and neonatal EPSDT screenings must include each of the following components:  
a. Identifying eligible enrollees at risk for lead absorption and performing a test for blood lead level. (The blood lead test is the only acceptable laboratory screening test. The erythrocyte protoporphyrin test is not acceptable as a screening test for lead poisoning.); " **Maine RFP**, Appendix 6, pages 3-6.

"...(11) Lead Toxicity Screening. The required screen for the presence of lead toxicity in children consists of two components: verbal risk assessment and blood lead testing.

(a) Verbal Risk Assessment. The provider must perform a verbal risk assessment for lead toxicity at every periodic visit between the ages of six and 72 months as indicated on the Schedule. The verbal risk assessment includes, at a minimum, the following types of questions: (I) Does your child live in or regularly visit a house built before 1960? Does the house have peeling or chipping paint?

(ii) Was your child's day care center/preschool/babysitter's home built before 1960? Does the house have chipping or peeling paint?

(iii) Does your child live in a house built before 1960 with recent, ongoing, or planned renovation or remodeling?

(iv) Have any of your children or their playmates had lead poisoning?

(v) Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community.

(vi) Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead, such as (give examples in your community)?

(vii) Do you give your child home or folk remedies that may contain lead?

(viii) Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?

(ix) Does your home's plumbing have lead pipes or copper pipes with lead solder joint?

A child's level of risk for exposure to lead depends upon the answers to the above questions. If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answers to any question is affirmative, a child is considered at high risk for high doses of lead exposure. A child's risk category can change with each administration of the verbal risk assessment...

(b) Blood Lead Testing. Screening blood lead testing may be performed by either a capillary sample (finger stick) or a venous sample. However, all elevated blood levels (equal to or greater than 10 micrograms or 1 deciliter) obtained through a capillary sample must be confirmed by a venous sample. The frequency with which the blood lead test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine and 12 months, and annually thereafter until the age of 48 months. For children determined to be at high risk for high doses of lead exposure, a screening blood lead test must be performed at the time a child is determined to be a high risk beginning at six months of age...

(i) If the initial blood lead test results are less than 10 micrograms per deciliter, a screening blood lead test is required at every subsequent periodic visit through 72 months of age, unless the child has already received a blood lead test at the periodic visit within the last six months.

(ii) If the child is found to have a blood lead level equal to or greater than 10 micrograms per deciliter, providers should use

their professional judgement, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood test and initiation of investigations, to determine the source of lead, where indicated.

(iii) If a child between the ages of 24 months and 72 months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions..." **Massachusetts Contract**, Appendix E, Section I, unnumbered pages.

"The components of the program are the following...

As specified in federal regulations, the screening component involves a general health screening most commonly known as a periodic well-child exam. EPSDT screening guidelines are based on the American Academy of Pediatrics' recommendations for preventive pediatric health care and include at a minimum:

lead toxicity screening age 1-5 with blood sample for lead level determination as indicated interpretive conference and appropriate counseling for parents or guardians." **Michigan RFP**, page 27.

"...1. Services Included... All services must be provided consistent with the scope of services covered by the Michigan Medicaid Program on a fee-for-service basis, unless otherwise specified by the Department. Health plans must reference all

applicable Medicaid provider manuals and publications for coverages and limitations... Blood lead follow-up services for individuals under the age of 21." **Michigan RFP**, pages 21-22.

"... If a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, a referral should be made to the local health department for follow-up services which may include an epidemiological investigation to determine the source of blood lead poisoning." **Michigan RFP**, pages 27-28.

**"6.10 Early Periodic Screening Diagnosis and Treatment Services (EPSDT)** The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens. Toward that end, the Contractor shall provide the full range of EPSDT services as defined in, and in accordance with, the Division's policies and procedures for EPSDT and the provisions of this Contract. Such services shall include, without limitation, periodic health screenings...

in accordance with the Periodicity Schedule established for EPSDT services including... all medically necessary services... The following minimum elements are to be included in the Periodic Health Screening Assessment...

e. Blood lead levels must be tested pursuant to Appendix N of the EPSDT provider manual. " **Mississippi HMO Contract**, page 19.

"6.2.1 The health plan must conduct periodic early and

periodic, screening, diagnosis, and treatment screens on all members under age twenty-one (21) to identify health and developmental problems. These screens include the following components: ...

(g) Blood lead testing (mandatory 6-72 months)..." **Missouri RFP**, page 29.

"10.7.1 Plans are responsible for ensuring the following core services are available to their members and for reimbursing the Department of Health and local health departments as specified...

(e) Childhood lead poisoning prevention services including screening, diagnosis and treatment. Plan providers shall follow current CDC guidelines: Preventing Lead Poisoning in Young Children. The Director of the Department of Health shall provide the plan's medical director with copies of current protocols and guidelines upon contract award or at any time upon request.

10.7.2 Other services offered by the Department of Health and local health departments and the method of reimbursement include:

(a) Environmental lead assessments for plan children with elevated blood levels will be reimbursed directly by the state Medicaid agency...." **Missouri RFP**, pages 34, 34A, 34B, 35

"CASE MANAGEMENT-HCY and LEAD CASE

## MANAGEMENT (HCY)

**HCY Case Management:** Health plans are required to provide medically necessary case management services for persons under the age of 21. **Healthy Children and Youth (HCY) Case Management** is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate services for a person under age 21 rests with a health plan or an organization or individual with which the health plan has contracted. **HCY Case Management** is the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment 'loop'.

**HCY Case Management** can be used to reach out beyond the bounds of the Medicaid program or health plan to coordinate access to a broad range of services, regardless of the source of funding for the services. The services to which access is gained must be found by the health plan to be medically necessary for the child. **HCY Case Management** services are intended to assist individuals in gaining access to needed medical, social, educational and other services. The health plan may assist the individual in accessing these services.

**Lead Case Management:** Plans must screen children for elevated blood lead levels as part of the requirement for the EPSDT/HCY program. When a child is

identified with an elevated blood lead level, the health plan is responsible for providing medically necessary services including case management for the child. For those children who are enrolled in the Managed Care program, the health plan will be responsible for provision of the lead case management services... " **Missouri RFP**, Attachment 8, pages 129,130.

"Give each ENROLLEE, including adolescents, the opportunity go to any public health clinic for immunizations and blood lead testing (but not well-child screens) without requiring a referral. The CONTRACTOR shall also make a reasonable effort to contract with all county public health clinics. At a minimum the contractor shall reimburse such public health clinics at the MEDICAID rate. The CONTRACTOR may require public health clinics to submit claims or reports in specified formats before reimbursing services." **Montana Contract**, pages 1-10.

"10. Lead poisoning screening for children under the age of six (6) and when medically necessary following the recommended medical protocols by the Childhood Lead Poisoning Prevention Program, Division of Public Health Services: ..." **New Hampshire RFP**, Exhibit A.3, page 3.

"ATTACHMENT I EPSDT Protocol... The contractor must provide EPSDT equivalent services...

1. EPSDT Screening Services which include:

d. Appropriate laboratory tests: The following list of screening tests is not all inclusive; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary: ...

blood lead assessment using blood lead level determinations as part of scheduled periodic health screenings appropriate to age and risk must be done for children between 6 months and 6 years of age according to the following schedule: ... between 6 months and 12 months at 24 months of age annually to six (6) years of age...

All screening must be done through a blood lead level determination. The EP test is no longer acceptable as a screening test for lead poisoning;" **New Jersey Contract**, pages 135-136.

"NOTE: HCFA considers all Medicaid recipients between 6 months and 6 years of age to be at risk for elevated blood lead levels.

All screening must be done through a blood lead level determination. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia...." **New Jersey Contract**, Appendix A, page 130.

"2.8.9.5 Lead Poisoning Health plan PCPs will be responsible for screening, diagnosing and treating children with elevated

blood lead levels. Plans/PCPs also must coordinate the care of such children with local health departments to assure appropriate follow-up by the departments in terms of environmental investigation and risk management." **New York RFP**, page 46.

"Screening

The HMO must conduct periodic EPSDT screens on all members under age twenty-one (21) to identify health and developmental problems. These screens must be in accordance with the periodicity schedule developed by the Department as recommended by the American Academy of Pediatrics. These screens include:

Blood lead levels as appropriate and consistent with current Centers for Disease Control (CDC) standards. " **Pennsylvania RFP**, page 40.

"SCREENING

The Health Plan must conduct periodic EPSDT screens on all members under age 21 to identify health and developmental problems. At a minimum, these screens must include:

Laboratory tests including lead, TB, newborn screening as medically indicated " **Rhode Island Contract**, page 24.

"PRENATAL AND POSTNATAL CARE SHALL INCLUDE



**A) Initial Prenatal Visit...**

As needed... -

Lead screening;... " **Tennessee Contract**, Guidelines, pages 48-54.

**"21. Services to CHEC Enrollees**

HMO shall provide to CHEC participants any service, covered under Medicaid, that is necessary to treat or ameliorate a defect, physical illness, or a condition identified by a screen regardless of whether the service or item is otherwise included in a State's Medicaid plan. HMO shall provide preventive services and treatment of children under age 21, as prescribed in the State Medicaid Provider manual for CHEC services, including the periodicity schedule as described in the CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels..." **Utah Contract**, Attachment C, unnumbered pages.

"b) EPSDT Periodic Screening - Components--A complete screening package includes the following components as appropriate for the age and sex of the child:...

(iv) Lead Toxicity Screening--Blood lead level assessments are required in accordance with HHS requirements. Blood lead testing may also be done at any time prior to or subsequent to the age- appropriate schedule if a history of high-risk or elevated blood lead results indicates the need for more frequent testing." **Virginia Contract**, pages 109-112.

"2.5.2.2 EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Services...

**a. Screening**

The Contractor must provided periodic EPSDT screens for members under age 21... At a minimum, these screens must include the following, Laboratory test (including lead)..." **Vermont Contract**, page 32.

**2.6.5 Lead Screening Program**

The health plan must have written policies and procedures to provide lead screenings and appropriate retesting in accordance with Health Care Financing Administration guidelines. The health plan must also provide for appropriate treatment services, such as medically-necessary chelation, and agree to coordinate delivery of these services with the Department of Health." **Vermont RFP**, pages 2-21 - 2-22.

"b. ...Reviewing elements include management of specific diagnosis, appropriateness and timeliness of care, comprehensiveness of and compliance with the plan of care, and evidence of special screening for, and monitoring of, high risk individuals or conditions which shall include at least five of the following clinical areas of concern:

(3) Lead toxicity." **Florida Contract**, page 46.

**"APPENDIX B CLINICAL AND HEALTH SERVICES  
DELIVERY AREAS OF CONCERN**

**Clinical Areas of concern...**

**Lead toxicity..." Kansas Contract**, Appendix B, pages 1,2.

"...(ii) If the child is found to have a blood lead level equal to or greater than 10 micrograms per deciliter, providers should use their professional judgement, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood test and initiation of investigations, to determine the source of lead, where indicated...."

**Massachusetts Contract**, Appendix E, Section I, unnumbered pages.

***Quality Assurance and Performance Measures***

"1. Services Included... All services must be provided consistent with the scope of services covered by the Michigan Medicaid Program on a fee-for-service basis, unless otherwise specified by the Department. Health plans must reference all applicable Medicaid provider manuals and publications for coverages and limitations... Blood lead follow-up services for individuals under the age of 21." **Michigan RFP**, pages 21-22.

"10.7.1 Plans are responsible for ensuring the following core services are available to their members and for reimbursing the Department of Health and local health departments as specified...

(e) Childhood lead poisoning prevention services including screening, diagnosis and treatment. Plan providers shall follow current CDC guidelines: Preventing Lead Poisoning in Young Children. The Director of the Department of Health shall provide the plan's medical director with copies of current protocols and guidelines upon contract award or at any time upon request.

"10. Lead poisoning screening for children under the age of six (6) and when medically necessary following the recommended medical protocols by the Childhood Lead Poisoning Prevention Program, Division of Public Health Services: ..." **New Hampshire RFP**, Exhibit A.3, page 3.

"An annual report of the Contractor's monitoring, evaluation, and findings regarding the following six (6) priority areas of concern identified by HCFA...

4. Lead toxicity..." **New Jersey Contract**, page 61.

"Performance Standards for EPSDT Services Service Standard Met EPSDT exam-age appropriate 75% Completed immunizations for age 75% Lead screening 75%." **New Jersey Contract**, Appendix A, Attachment I, page 137.

"Screening

The HMO must conduct periodic EPSDT screens on all members under age twenty-one (21) to identify health and developmental problems. These screens must be in accordance with the periodicity schedule developed by the Department as recommended by the American Academy of Pediatrics. These screens include:

Blood lead levels as appropriate and consistent with current Center for Disease Control (CDC) standards. " **Pennsylvania RFP**, page 40.

"TRACKING

Contractor shall establish a tracking system that provides

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up-to-date information on compliance with EPSDT service provision requirements in the following areas:

Preventive pediatric visits in accordance with the Rhode Island EPSDT periodicity schedule and Rhode Island Department of Health immunization and lead guidelines..." **Rhode Island Contract**, pages 26-27.

"H. CONTINUOUS QUALITY IMPROVEMENT...

4) HMO shall submit to TDH a report of the detailed information and analysis of the data for the required focused studies as directed by TDH - Pregnancy, EPSDT (including childhood immunizations and lead),...collected for the six month period ending February 1997, and thereafter in consecutive 6 month intervals (referred to herein as "reporting period"). The report shall be submitted to TDH within 150 days following the close of the reporting period..." **Texas Contract**, Appendix B, unnumbered pages.

"II. Report Specifications for Preventive Objectives...

D. Lead Toxicity Screening

The objective for calendar year 1997 is 50% of all Medicaid enrollees with their first or second birthday during the reporting period (calendar year 1997) who are continuously enrolled for the 12 months prior to their first or second birthday will have had one blood lead test. Two rates must be reported, one for one year olds and one for two year olds..." **Wisconsin Contract**, pages 151 - 155.

## ***Data Collection and Reporting***

"ADDENDUM III...

### **D.C. MEDICAID MANAGED CARE MONTHLY REPORTING FORMAT PREPAID HEALTH PLANS**

**Report 1 - EPSDT Screening, all members ages 0 through 20**

**Note: Detailed EPSDT screening information must be provided for every EPSDT procedures performed by patient**

**Patient ID# (D.C. Medicaid #)**

**Date of Birth**

**Date of Service**

**EPSDT Code #**

**(See Attached Listing)**

**Referred for Correction Treatment - Yes/No**

**EPSDT REPORTING CODES**

**DESCRIPTION LEAD Screening" District of Columbia  
Contract, Addendum III, pages 1, 2, 3.**

**"...All laboratory tests for children being screened for lead must be sent to the Department of Public Health's state laboratory."  
Illinois Contract, pages 11-13.**

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**"Medicaid Managed Care Provider Options/Mandates for coordinating with Department of Health Program and Services...**

**15. Lead Poisoning Prevention and Control**

**a) Screening and Treatment**

**b) Environmental Assessment... Plan must report... DOH/LHD must be reimbursed if they provide...**

**18. DOH Health Laboratory Service... DOH/LHD must be reimbursed if they provide..." Missouri  
RFP, page 100**

**"15.7 The contractor's QMP activities will also include, at a minimum:...**

**S. An annual report of the contractor's monitoring, evaluation, and findings regarding the following six (6) priority areas of concern identified by HCFA: ...**

**4. Lead toxicity..." New Jersey Contract, pages 59-61.**

**"NOTE: HCFA considers all Medicaid recipients between 6 months and 6 years of age to be at risk for elevated blood lead levels.**

**All screening must be done through a blood lead level**

determination. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia.

Results of lead screenings, both positive and negative results, must be reported to the local departments of health--the state funded County Childhood Lead Poisoning Center. Blood lead levels greater than twenty (20) micrograms per decaliter must be reported immediately, either via telephone or electronically...

**"2.8.9.5 Lead Poisoning Health plan PCPs will be responsible for screening, diagnosing and treating children with elevated blood lead levels. Plans/PCPs also must coordinate the care of such children with local health departments to assure appropriate follow-up by the departments in terms of environmental investigation and risk management." New York RFP, page 46.**

**"The HMO must provide information to the State CLPPP on childhood lead poisoning prevention services they provide including, but not limited to, the following types of data:**

**Screening;  
Case Management;  
Treatment;  
Tracking;  
Medical and Environmental Follow-up;  
Referrals for Early Intervention Services; and  
Education and Outreach Activities.**

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**This information will be necessary for the State CLPPP's surveillance system. The Department of Health will provide the HMO with STELLAR software for case management." Pennsylvania RFP, page 84.**

**"TRACKING**

**Contractor shall establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:**

**Preventive pediatric visits in accordance with the Rhode Island EPSDT periodicity schedule and Rhode Island Department of Health immunization and lead guidelines..."Rhode Island Contract, pages 26-27.**

**"2.08.08 Department Of Health Laboratory**

**The Rhode Island Department of Health operates a reference laboratory and relies on this laboratory to monitor the incidence of lead poisoning and contagious diseases throughout the State. To assist in this monitoring process, Contractor agrees to submit to the Department of Health laboratory all specimens for childhood lead screening, HIV testing, and mycobacteria (TB) analysis. Contractor also agrees to submit specimens from suspected cases of measles, mumps, rubella, and pertussis when required by the State to facilitate investigations of outbreaks. Contractor shall negotiate fees directly with the**

Department of Health laboratory." **Rhode Island Contract**, pages 38-39.

#### "H. CONTINUOUS QUALITY IMPROVEMENT...

4) HMO shall submit to TDH a report of the detailed information and analysis of the data for the required focused studies as directed by TDH - Pregnancy, EPSDT (including childhood immunizations and lead),...collected for the six month period ending February 1997, and thereafter in consecutive 6 month intervals (referred to herein as "reporting period"). The report shall be submitted to TDH within 150 days following the close of the reporting period..." **Texas Contract**, Appendix B, unnumbered pages.

#### "2.7.8 Department of Health Laboratory and Disease Reporting Requirements

Contractor shall submit all reference specimens for the confirmation of positive blood lead....

Contractor shall cooperate with the Department of Health and its laboratory in all investigations of illness, providing required information on cases as well as laboratory results and isolates of etiologic agents as appropriate and as spelled out in Vermont's communicable disease reporting law. It is the responsibility of the Contractor to comply with Vermont disease reporting requirements....The Contractor and/or their

participating providers (as applicable) who contract with out-of-state labs, are responsible for ensuring that the lab vendor complies with Vermont's disease reporting requirements...

In order to protect the public health, any condition which may be a public health risk should be reported to the Department of Health, Division of Epidemiology." **Vermont Contract**, page 40.

"Preventive Care Objectives --...the HMO must measure and report activity in the four Preventive Care areas...

4) Lead Toxicity Preventive Care Objective..." **Wisconsin Contract**, page. 33.

#### "II. Report Specifications for Preventive Care Objectives...

"All HMOs that contract with the Wisconsin Department of Health and Family Services (DHFS) to provide Medicaid services must submit the utilization data requested in the HMO Utilization Report.

#### A. HMO Utilization Report...

4. Report all services the HMO actually paid for. In, addition, the HMO may report services it expects to pay for (i.e., claims incurred but not yet paid) through the reporting period...

7. a. Assignment of member months to an age category: When calculating member months for each age category, use the member's age on the day of each month on which membership is tallied... b. Assignment of age for utilization questions: Report age as of date of service for all other utilization measures. For inpatient admissions report age as of date of discharge...

9. Do not count the same procedure twice for the same date of service...

12. Treat transfers between institutions as separate admissions except where otherwise instructed. Report separate admissions when the transfer is between acute and non- acute levels of services, and mental health/AODA and acute services.

13. Report inpatient utilization by discharge date rather than admission date...

16. The HMO Utilization Report data must be reported in the computer readable format. The report layout is specified in the Utilization Reporting Users Manual." **Wisconsin Contract, pages 90 - 92.**

"...H. Number of unduplicated enrollees under age 6 receiving blood testing: (submit all recipient history for all enrollees included in this category)..." **Wisconsin Contract, pages 98-103.**

"A1. Number of unduplicated enrollees under age 21 who received at least one comprehensive Health check screen and total number of screens provided: (submit all recipient history data for all enrollees included in this category)..."

Laboratory tests (including appropriate blood-lead screening and testing)...

A2. Number of unduplicated enrollees who have received a HealthCheck screening and were referred for diagnostic/treatment services as a result of the screen: (excluding vision, dental and hearing services)... " **Wisconsin Contract, pages 99-100.**

### *Relationships with Public Health Agencies*

"...If a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, a referral should be made to the local health department for follow-up services which may include an epidemiological investigation to determine the source of blood lead poisoning." **Michigan RFP, pages 27-28.**

"10.7.1 Plans are responsible for ensuring the following core services are available to their members and for reimbursing the Department of Health and local health departments as

specified...

(e) Childhood lead poisoning prevention services including screening, diagnosis and treatment. Plan providers shall follow current CDC guidelines: Preventing Lead Poisoning in Young Children. The Director of the Department of Health shall provide the plan's medical director with copies of current protocols and guidelines upon contract award or at any time upon request.

10.7.2 Other services offered by the Department of Health and local health departments and the method of reimbursement include:

(a) Environmental lead assessments for plan children with elevated blood levels will be reimbursed directly by the state Medicaid agency...." **Missouri RFP**, pages 34, 34A, 34B, 35

#### "2.5 Public Health Clinic Access

Give each ENROLLEE, including adolescents, the opportunity go to any public health clinic for immunizations and blood lead testing (but not well-child screens) without requiring a referral. The CONTRACTOR shall also make a reasonable effort to contract with all county public health clinics. At a minimum the contractor shall reimburse such public health clinics at the MEDICAID rate. The CONTRACTOR may require public health clinics to submit claims or reports in specified formats before reimbursing services." **Montana Contract**, pages 1-10.

"10. Lead poisoning screening for children under the age of six (6) and when medically necessary following the recommended medical protocols by the Childhood Lead Poisoning Prevention Program, Division of Public Health Services: ..." **New Hampshire RFP**, Exhibit A.3, page 3.

"2.8.9.5 Lead Poisoning Health plan PCPs will be responsible for screening, diagnosing and treating children with elevated blood lead levels. Plans/PCPs also must coordinate the care of such children with local health departments to assure appropriate follow-up by the departments in terms of environmental investigation and risk management." **New York RFP**, page 46.

"The HMO must provide information to the State CLPPP on childhood lead poisoning prevention services they provide including, but not limited to, the following types of data:

- Screening;
- Case Management;
- Treatment;
- Tracking;
- Medical and Environmental Follow-up;
- Referrals for Early Intervention Services; and
- Education and Outreach Activities.

This information will be necessary for the State CLPPP's surveillance system. The Department of Health will provide the HMO with STELLAR software for case management." **Pennsylvania RFP**, page 84.



**"2.07 COORDINATION WITH OUT-OF-PLAN SERVICES AND OTHER HEALTH/ SOCIAL SERVICES AVAILABLE TO MEMBERS...**

**2.07.04.02 Lead Program**

**The Department of Health provides a variety of services within its Lead Program, including case management, home assessments, environmental interventions, and consultation to providers. Contractor agrees to have written policies and procedures to provide lead screening education, and any medically necessary lead reduction therapies and must agree to work cooperatively with the Department of Health Lead Program to coordinate delivery of these services with those provided through the Department of Health." Rhode Island Contract, pages 31, 33.**

**"2.5.2.2 EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Services...**

**2.6 Coordination With Out-of-Plan Services**

**The Contractor is not obligated to provide or pay for any non-capitated services. However, Contractor must establish processes to coordinate in-plan service delivery with services delivered outside the plan... Consultation should occur between the health plan provider and the out of plan provider where clinically appropriate. The areas where coordination between**

**health plans and other services is a priority are the described in the RFP, including coordination with the following.. Lead Screening Program..." Vermont Contract, pages 32, 35.**

**"2.6.5 Lead Screening Program**

**The health plan must have written policies and procedures to provide lead screenings and appropriate retesting in accordance with Health Care Financing Administration guidelines. The health plan must also provide for appropriate treatment services, such as medically-necessary chelation, and agree to coordinate delivery of these services with the Department of Health." Vermont RFP, pages 2-21 - 2-22.**

**"The following specific services have been delineated with the hope of linking Medicaid Managed Care Plans with Local Health Departments. Linking primary care and public health is an essential strategy to strengthen the health of local communities and thus benefit the population of the state as a whole....**

**LHDs provide health-related home/community inspections in areas that include Lead Poisoning, " Wisconsin Contract, pages 160-161.**