

# **Track, Monitor, and Respond**

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## ***Three Keys to Better Lead Screening for Children in Medicaid***

**Cooperative Agreement 18-C-91119/3-01**

***Submitted to***  
**The Centers for Medicare and Medicaid Services**

***by***  
**The Alliance To End Childhood Lead Poisoning**

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## Introduction and Purpose

The primary audience for *Track, Monitor, and Respond* is people in regional, state, and local Medicaid offices with responsibility for carrying out policy of the Centers for Medicare and Medicaid Services (CMS) on lead screening and follow-up care for young Medicaid beneficiaries. Included in this intended target audience are state Medicaid agency (SMA) personnel—administrators, EPSDT coordinators, quality assurance specialists and managers, and others who work closely with health care providers and managed care plans to develop and monitor performance specifications.

The purpose of the following materials is to facilitate problem solving by providing information on tracking, monitoring, and responding to lead screening efforts of managed care plans and health care providers. Such screening is a required component of EPSDT<sup>1</sup> because, as a group, young children in Medicaid are more likely than other children to be exposed to lead.<sup>2</sup> Most often, their exposure is due to the presence of lead paint hazards in their homes. Such exposure is associated with difficulties in learning and behavior, but these problems can be mitigated for children whose exposure comes to light because of blood lead screening and who receive timely and appropriate follow-up care. Central to improving lead screening is promotion of this service among health care providers, using the information about screening penetration and case finding that good tracking makes available. CMS's inclusion of lead screening data in the required annual CMS Form 416 report further underscores the importance of tracking the provision of this service.

The materials are divided into three sections designed to build upon each other:

- The Tracking section has recommendations on collecting essential information on lead screening;
- The Monitoring section has suggestions on strategies for utilizing this information;
- The Responding section is a case-study of a visible and effective response to health care providers that is based on tracking and performance monitoring.

By making lead screening and follow-up care available to our nation's highest-risk children, the Medicaid program plays a central role in preventing lead poisoning and its consequences. The following materials, designed to be quickly and easily read and to refer the reader to more extensive sources where necessary, are intended to stimulate new strategies and efforts that will further strengthen this role.

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<sup>1</sup> US Health Care Financing Administration, State Medicaid Manual, Part 5 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Section § 5123.2, September 1998. Department of Health and Human Services, Health Care Financing Administration.

<sup>2</sup> US General Accounting Office, Medicaid: Elevated Blood Lead Levels in Children, GAO/HEHS-98-78, February 1998.

## Acknowledgements

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## TRACKING

# Getting the Data You Need Through Productive Partnerships

**Good tracking data is central to efforts to improve lead screening for children in the Medicaid program.** Never was this more true than now, as new relationships with managed care plans have increased the monitoring functions of state Medicaid agencies (SMAs).

**There are two main sources of tracking information for lead screening:**

- Provider reports, in the form of encounter data, and
- Laboratory reports, which are usually maintained in state health department surveillance systems.

**In many jurisdictions, health department surveillance systems can be used to support or supplant provider reports for tracking screening events and cases.**

Developing effective partnerships is the key to harnessing the power of these systems for Medicaid tracking and monitoring.

**What data are usually present in the blood lead surveillance system?** Systems usually contain basic information such as name, date of birth, date and result of lead tests, provider's name, and, less frequently, address and demographics for all tested children.

**What data are usually missing?**

The key piece of information about the children in the system that is often missing is Medicaid status. This bit of information is very important to the health department, which, like the SMA, needs to know who in this group is or is not receiving proper lead screening.

**The benefits of partnership.** By combining data elements from the state Medicaid enrollment system and the blood lead surveillance system, SMA personnel can track Medicaid lead screening in an accurate and timely way.<sup>3</sup>

### **In A Nutshell: The Typical Health Department System for Blood Lead Surveillance**

**The System's Foundation: Lab Reports.** Childhood blood lead surveillance systems are based on laboratory reporting of the results of blood lead tests. Most states require laboratories to report to a state entity, usually the health department.

**Four Important System Attributes.** Health departments strive to build a blood lead data system that is complete, accurate, timely and electronic.

**A System "Must."** Most importantly, all blood lead levels must be reported so that both screening and case information is captured. Lacking such a requirement, it is impossible to track screening events and case rates.

**Future Trends.** Under the Children's Health Act of 2000, the Centers for Disease Control and Prevention (CDC), a major funder of state blood lead surveillance systems, must establish surveillance requirements for its grantees to ensure uniform and complete lab reporting, and work to improve data linkages between health departments and CDC, as well as with WIC, Early Head Start, and other programs. As a result, blood lead surveillance data should become more reliable and comparable across states.

<sup>3</sup> For how-to information on combining data elements see The Foundations of Better Lead Screening for Children in Medicaid. Hard copies are available from the Alliance To End Childhood Lead Poisoning. This document can also be downloaded from the Alliance website, [www.aeclp.org](http://www.aeclp.org). (See Additional Resources for more information.)

## TRACKING

# Five Key Elements for Healthy Data-Sharing Partnerships Between State Medicaid Agencies and Health Departments

The following five elements are synthesized from information provided by states whose successful data-sharing partnerships have helped to improve Medicaid lead screening.

### **Element 1: Background**

At the outset of a joint data-sharing project, representatives of the SMA and the health department should be able to answer these questions:

- What benefits does my agency expect to gain from the partnership?
- What roles and responsibilities does my agency expect to assume?
- What resources (staff time, software support, etc.) does my agency expect to contribute?
- Who are the staff members from my agency who are designated to carry out this project?
- Are senior staff aware of the need for the partnership?

### **Element 2: Favorable Institutional Environment**

- Top-down support for the joint project. (This can go a long way toward compensating for the absence of the following three circumstances, which are out of your control.)
- History of strong ties and good relationships between the partner agencies.
- Partner agencies located within a single state agency.
- Partner agencies physically located in the same building.

### **Element 3: A Good Start.**

- Identification of key project staff. These are likely to be: database managers and maternal and child health policy specialists from each agency, the health department lead surveillance coordinator, SMA quality assurance specialist.
- Preparation of a joint briefing document on the project. Should be done as early as possible.
- Getting buy-in of senior staff of each agency. Imperative for ensuring later support.

### **Element 4: Preparation for dealing with privacy and confidentiality issues.**

- Familiarity with agencies' privacy policies and whom to ask for specific guidance.
- Utilization of the letter from the heads of CMS, HRSA, and CDC sent to all state health officials and all state Medicaid directors (December 1, 1998). This letter calls for inter-agency data sharing, includes a model data-sharing agreement, and is found at <http://www.hcfa.gov/medicaid/smd10228.htm>
- Problem solving: For example, even if a state health department withholds the results of tests, it can share names of children who received blood lead testing. Similarly, the SMA may be able to indicate which children in the blood lead surveillance database are enrolled in Medicaid, while withholding private information. In both of these cases, more extensive information sharing would be preferable, but limited sharing may be an improvement over the status quo.

### **Element 5: Acknowledged mutual dividends and potential for additional benefits.**

- Regular joint status reports on the project, focusing on benefits accrued to the participating agencies.
- Itemization of additional benefits accruing to both agencies from continuation and expansion of data sharing.

# MONITORING

## A Fact Sheet on Quality Assurance

### What gets measured gets done.

Monitoring performance and identifying and pursuing improvement among providers who do not routinely screen children for lead can improve screening rates for Medicaid enrolled children.

### Health departments and SMAs should develop data-sharing agreements. Such a partnership makes it possible to combine and analyze data from childhood blood lead surveillance systems and state Medicaid data systems, yielding key benefits:

- *Tracking for the most vulnerable children.* Creates a reliable system for tracking screening among the vulnerable Medicaid population.
- *Oversight of managed care plans and providers.* Makes it possible to identify and reward managed care plans and providers with high rates of lead screening and to require improvement among providers with low rates, especially where reliable encounter data is unavailable.
- *Tracking of outcomes.* Enables SMAs to document rates of elevated lead levels among children in Medicaid—and to use this information to inform providers about lead exposure in the population they serve. *For most providers, evidence of elevated blood lead levels among their patients is the single most important motivator to do more screening.*
- *Better reporting.* Helps SMAs to achieve more complete and accurate reporting of lead screening on the annual CMS 416 report.
- *Better decisions.* Makes possible informed decisions about future targeting of lead screening to the sub-groups of Medicaid beneficiaries who are at highest risk.

### States should capitalize on the promise of Medicaid managed care:

- *Managed care purchasing agreements.* SMAs should ensure that RFPs and purchasing agreements include explicit lead screening requirements and provisions for follow-up care for children with elevated blood lead levels.<sup>4</sup>
- *Encounter data.* Lead screening rates can be extracted from analysis of the claims data submitted by providers to managed care plans, and used to track, compare, and incentivize screening.
- *QAPI: standardized performance measures.* SMAs should use CMS's Quality Assessment And Performance Improvement (QAPI) Program to establish minimum performance levels on standardized quality measures and require managed care plans to report their performance and achieve established levels. SMAs should choose lead screening as a standardized quality measure. For example, a

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<sup>4</sup>Sample specifications for SMAs to use in writing purchasing agreements with managed care plans are available on diskette and on the internet free of charge from George Washington University Center for Health Services Research and Policy. See Additional Resources.

state Medicaid agency might require all managed care plans with Medicaid enrolled children to achieve, at a minimum, a specific numerical rate (e.g., 80 percent) of lead screening among these children.

- *QAPI: performance improvement projects.* Managed care plans must conduct performance improvement projects in which they demonstrate sustained improvement in selected aspects of care. Childhood lead screening is a natural choice of important and measurable.

**Managed care plans should play a key role in improving Medicaid lead screening rates of participating providers.**

- *Independent chart audits.* While chart reviews are labor intensive, they may be a necessary tool for comparing screening rates among practices or providers.
- *Data matching.* Managed care plans can provide to the health department lists of their one- and two-year-old enrollees with no record of screening, to be matched with health department blood lead surveillance data. Such a match will ensure that the MCO has the most complete documentation of lead screening possible. And because some children whose screening was unknown to the MCO will usually be identified, the match will often result in a smaller group of children who need intensive outreach to ensure appropriate screening.
- *Comparisons.* Monitor and compare screening rates among providers in an MCO, and provide feedback on this information to providers, discussing the relevance of the comparative rates and the importance of lead screening among Medicaid enrolled children.
- *Financial incentives.* Incentives should be considered for high-performing contracted providers and clinic systems.



## MONITORING

### Focusing Efforts Where They Count the Most

#### Identifying Individual Unscreened Children

For some SMAs, achieving gains in lead screening among young Medicaid beneficiaries will require intensive effort focused on key providers. Most useful is to identify individual high risk children who have not received lead screening.

#### Sources of Information

In some states, it is possible to identify these individuals by linking Medicaid enrollment data with blood lead surveillance data. In other places, as in the Rhode Island scenario described below, it may be possible to use public health registries of immunizations and other preventive services that are built on birth records and contain the names of the young children in a birth cohort of interest.

#### Targeting Strategies

Targeting providers who serve unscreened individuals may be very useful in places with defined neighborhoods with high rates of old housing and children enrolled in the Medicaid program. The state Medicaid agency can use its enrollment database to identify managed care plans and providers with unscreened high-risk enrollees, and furnish these providers the names of children who require screening. The success of this strategy may depend in part on the presence of detailed purchasing agreements that require lead screening and can be used as the basis for insisting upon improvement in this service.

#### Intensive monitoring in Central Falls, Rhode Island

Central Falls is a culturally diverse city five miles north of Providence. The town is small, densely populated, and has a high concentration of poverty, old housing, multi-family rental units, and young children—key predictors of lead exposure.

Rhode Island's KIDSNET database has address, age, and lead screening information for almost the entire pediatric population of Central Falls, making it possible to determine the screening status of individual children who live in the city. The lead team from the Rhode Island health department extracted from KIDSNET records for all children more than 15 months old who had no evidence of lead screening. (The cut-off point of 15 months of age was selected in order to allow a three-month period for screening to take place and to be recorded in KIDSNET.) Of the 932 children living in Central Falls who had active records in KIDSNET, 130 (14%) children had both a recorded census tract and no record of having received a blood lead test. The majority (82%) of these children lived in 4 census tracts that comprise the core of Central Falls and that are home to people living in extreme poverty.

The record of each child in the KIDSNET database includes the name of the child's primary health care provider. The team identified in a single health center, 57 children without a record of lead screening. A subsequent chart review revealed that a total of 53 children had not been tested. These children comprise 43% of all children less than 40 months old in this high-risk area who were without lead screening. The lead team provided the health center with a detailed report of the data, including a list of children who had not been tested, and made recommendations for improvement. Their ongoing evaluation of the results has two components. First, establishing that the individual children were tested. Second, ensuring sustained change in the health center staff's practice.

## RESPONDING

### Rewarding Accomplishment

Tracking and monitoring lead screening makes it possible to respond to health care providers on the basis of their performance. Many SMAs use some form of provider incentive to reward high levels of accomplishment, especially of EPSDT goals. Maine's use of these incentives to improve Medicaid lead screening is described below as an example.

#### Maine's Primary Care Providers' Incentive Program

Childhood lead exposure is relatively common in Maine, where 41 percent of the housing was built prior to 1950. In 1999 only 18% of one- and two- year-old Medicaid beneficiaries received lead screening, despite CMS requirement. The state public health laboratory performs all analysis of blood lead samples drawn from Maine children under six years of age and collects and manages data on all blood lead screening and follow-up tests. Analysis of these data from 1994-1999 revealed that Maine children who receive Medicaid benefits are twice as likely to be lead poisoned as their non-Medicaid counterparts.

The staff of the state Medicaid agency, which is housed in the Maine Department of Human Services, worked with staff of the lead program, housed in the same Department, on a project, known as the Primary Care Providers' Incentive Program (PCPIP) to furnish an incentive to health care providers for serving Medicaid beneficiaries. The aims of the PCPIP were to reduce financial disincentives for providers with high proportions of Medicaid beneficiaries in their patient populations, reduce inappropriate utilization of hospital emergency rooms, and increase utilization of preventive services. With regard to the lead screening, incentives were chosen over punitive sanctions such as fines because of evidence that many health care providers were unaware of Medicaid lead screening requirements. The strategy included efforts to inform providers about these requirements and to monitor individual provider screening rates and progress.

Under the PCPIP, providers who meet a set of identified parameters qualify for a quarterly financial incentive. In 1997, lead screening for children at 12 and 24 months of age was added to the program. Physicians were scored on the number of Medicaid patients they served, the number of emergency room visits by their patients, and the number of appropriate preventive exams (including blood lead screening) they performed. Those performing above a certain score received quarterly financial bonuses. As an additional incentive, the state Medicaid agency calculated quarterly Medicaid lead screening rates for individual pediatric and family practice providers and reported these rates in a mailing to all providers participating in the state Medicaid program. Included in each report was an "honor roll" of providers who achieved the greatest increases in lead screening.

Staff of the state Medicaid agency analyzed lead screening data collected during five quarters after the PCPIP began to include lead screening. Their analysis revealed a slight increase, from 15 percent to 18 percent, in the overall rate of screening of one- and two-year old Medicaid beneficiaries. However, the rates at which certain providers performed lead screening increased markedly. For example, in the first five quarters of the incentive program, the number of providers who were screening more than half of their young Medicaid beneficiaries more than doubled, from 12 to 25.

## Additional Resources

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1. *Lead Screening for Children in the Medicaid Program: A Tool Kit* is a packet of background and how-to information, including CMS guidance on lead screening, CDC recommendations, fact sheets, and The Foundations of Better Lead Screening for Children in Medicaid: Data Systems and Collaboration, a set of case-studies on states' strategies for improving this service. You can receive the Tool Kit free from the Alliance To End Childhood Lead Poisoning by calling 202-543-1147, or by emailing the Alliance at [aeclp@aeclp.org](mailto:aeclp@aeclp.org). You may also download most of the Tool Kit contents from the website.

2. Sample purchasing specifications for lead screening and follow-up care have been developed by the Center for Health Services Research and Policy at the George Washington University School of Public Health and Health Services with funding from CDC. The sample specifications, which are part of a Sample Purchasing Specifications Series, are available at no charge at <http://www.gwu.edu/~chsrp/>. They also may be obtained free of charge in diskette format from:

The George Washington University Medical Center  
Center for Health Services Research and Policy  
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