While many states struggle to find funding for childhood blood lead testing and follow up, TX DSHS and GA DOH have secured Medicaid reimbursement funding to support their programs. These funds have been used to support staff collecting, analyzing and reporting childhood blood lead data, providing information to parents and health care providers, conducting Environmental Lead Inspections (ELI), and conducting lead inspections. Further details of the programs can be found below.

Texas Lead Program Funded Through Medicaid Reimbursement

The Texas Department of State Health Services (DSHS) now sustains the Texas Childhood Lead Poisoning Prevention Program (TxCLPPP) through Medicaid reimbursement for surveillance and inspections.

While many states struggle to find funding for childhood blood lead testing and follow up, DSHS has secured Medicaid reimbursement to support staff collecting, analyzing and reporting childhood blood lead data, providing information to parents and health care providers, and conducting Environmental Lead Inspections (ELI).

Steps Taken:
DSHS worked with the State Medicaid Agency, the Texas Health and Human Services Commission (HHSC), on classifying childhood blood lead surveillance and follow up as a reimbursable state Medicaid service. In the 2011 TxCLPPP secured reimbursement for program services through two separate mechanisms. Through the Medicaid Administrative Claim Process, TxCLPPP receives funding for surveillance, data management, case coordination and provider and patient education. Through the Provider Enrollment Claim Process, TxCLPPP receives funding for Environmental Lead Investigations (ELIs) conducted by the program’s two lead risk assessors.

Texas law requires reporting of blood lead test data for children under the age of 15. Tests are typically conducted during routine physician exams and data is submitted to the Texas Child Lead Registry. TxCLPPP staff receive blood lead data from health care providers, analyze the data for trends and to identify high-risk areas, and report it to the CDC and the appropriate local health department. They determine if follow up actions are necessary, work with local laboratories to ensure quality in reporting practices, and communicate with health care providers about program functions and policy changes. When elevated blood lead tests are identified (blood lead levels ≥ 10 µg/dL), TxCLPPP provides parent and provider education about exposure and discusses options. An ELI is required for all elevated blood lead tests. TxCLPPP sends a certified lead risk assessor to the child's home to check for lead hazards and assess potential exposure sources in those counties in Texas where local health departments are unable to conduct ELIs.
Obtaining reimbursement for surveillance, data management, care coordination and education through the Medicaid Administrative Claim Process required the State Medicaid Agency, HHSC, to send a letter on behalf of TxCLPPP to the regional CMS office notifying them of their plan to begin billing. TxCLPPP also had to provide thorough documentation to justify reimbursement and describe current program activities that fall within the scope. The State Medicaid Agency, HHSC provided DSHS invaluable technical assistance on interpretation of federal laws and documentation needed to support implementation.

The reimbursement amount was calculated using blood lead surveillance data from a prior year. Since 87% of child blood test results reported to TxCLPPP for inclusion in the registry are from Medicaid enrolled children, the program receives reimbursement for eligible staff salaries based on the percent of Medicaid enrolled children served. Currently TxCLPPP is reimbursed 50% of 87% of staff salaries for staff providing services that meet the criteria for reimbursement under a Medicaid administrative claim. TxCLPPP anticipates that this percentage (87%) will increase over time as the number of Medicaid-eligible children tested increases; improvements in provider reporting practices; and continued enhancements in the Child Lead Registry.

The Provider Enrollment Claim Process allows health care providers to request an ELI for a lead poisoned child and bill Medicaid for the services. Getting this process in place required obtaining both federal and state provider billing codes for the health department, creating appropriate forms, and providing input on reimbursement rates to Medicaid policy-makers. Two lead risk assessors are employed by TxCLPPP and conduct about 100 ELI's per year statewide.

Results:
TxCLPPP now receives a significant portion of funding (50% of 87% of the salaries of 16 FTEs) for staff from Medicaid reimbursement for childhood blood lead surveillance, data management, case coordination, provider and parent education and ELIs. The process of investigating and implementing two Medicaid billing processes required a dedicated FTE and took almost two years of DSHS and Medicaid staff working closely together. As funding for lead programs around the country continues to dwindle, Texas has found a way to sustain crucial services for lead poisoned children into the future.

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State Stories: Medicaid Reimbursement for Childhood Lead Poisoning Services

Georgia Ensures Continuity in Services to Lead-Poisoned Children
When CDC funding for lead poisoning prevention programs was eliminated, Georgia's health department was able to sustain services through Medicaid reimbursement for lead inspections, and partnering with the federal housing agency to build capacity.

Policy Brief:
Georgia was funded by the CDC for a lead and healthy homes program for many years. The Georgia Department of Health, Environmental Health Section (DOH) invested significant resources to build capacity for staff to conduct lead inspections, and fulfill the requirements of the state law that mandates ongoing surveillance and monitoring of lead poisoning. Lead poisoning is a reportable illness in GA, so the DOH collects testing information regardless of funding. By partnering with the state Medicaid agency to create new billing codes, Georgia created a mechanism for reimbursement for lead inspections. Despite recent lead program funding cuts, they were able to sustain some program functions at the state and local level.

Steps Taken:
Exposure to lead can affect almost every system in the body. Even at low levels has been linked to lower IQ, academic achievement, and cognitive function and behavioral and attention problems. Lead exposure is also a health equity issue, as it impacts children in low-income communities and communities of color at higher rates. Homeowners and renters alike may not have the knowledge or resources to eliminate the sources of lead in their home.

The Georgia Healthy Homes and Lead Poisoning Prevention Program aims to eliminate childhood lead poisoning. DOH partners with 18 local public health districts to test, monitor and provide resources for children with elevated blood lead, and with inspectors to provide training, capacity building and resources for abatement in homes.

When CDC program funding was eliminated in 2011, the DOH was forced to reduce their staff from five to two, a program director and an epidemiologist. Additional reductions were made to the seven regional lead and healthy homes coordinators conducting inspections in high-risk communities.

Results:
The DOH was able to use funding from US Department of Housing and Urban Development (HUD) grant to support the two state staff, provide a coordinator for one high-risk county, conduct trainings, certify at least one environmental health specialist from each public health district in lead and healthy homes, and rehabilitate some homes in high-risk counties. Now Georgia has approximately 50 certified healthy homes staff and 30 certified lead inspectors.

In 2012 alone, 116,200 children in Georgia were lead tested. Almost 700 of those tested met the criteria for home inspections (blood lead level \( \geq 10 \mu g/dL \)).

After CDC's most recent guidance noted a health risk at lower lead levels (\( \geq 5 \mu g/dL \)), DOH began providing additional information and resources to families whose children fall in that range.

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According to Georgia state law and request of the CDC, surveillance and monitoring needed to continue in the absence of funding. Luckily, the DOH had previously developed a relationship with the state agency that administers the Medicaid program. In 1994, DOH staff worked with the Georgia Department of Community Health, Medical Assistance Plans Division (DCH) to create Medicaid billing codes that would allow lead inspectors to be reimbursed with Medicaid dollars for their services. The two codes cover environmental investigation (includes lead testing, providing education and a written report) and a notice to the property owner with remediation suggestions. All reimbursement received from Medicaid goes directly towards funding local health department inspectors. Considering that approximately 80% of lead inspections conducted in Georgia are for children covered by Medicaid, this revenue ensures that most of the state’s highest-risk children receive appropriate attention.

Recently, DOH noticed that private organizations contracted by the state to provide Medicaid services were not reimbursing lead inspectors. DOH worked closely with the DCH and these organizations to rewrite the existing policy to ensure payment for lead services, and worked with local health departments to ensure they are billing for services. DOH is also working with DCH to update reimbursement rates from the 1994 amounts.

Building off the 1994 precedent, the DOH’s environmental health and health promotion teams are now partnering to create billing codes for healthy homes inspections. Asthma was recently named a strategic priority for the DOH, so the aim is to secure Medicaid reimbursement for Asthma-related inspections. They would also like to develop a mechanism for physicians to refer asthmatic children to the DOH for a healthy homes inspection.

Lessons Learned:
DOH has also learned a great deal about the Medicaid process over the years. It’s important to match requests with the annual billing manual updates, and start engaging partners early in the process. Together, the HUD grant and the Medicaid reimbursement provide a revenue source for the DOH that allows them to continue state lead program operations and services in compliance with state law.

References:

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