

Congress of the United States
Washington, DC 20515

June 21, 2016

Mr. Andrew M. Slavitt
Acting Administrator, Center for Medicare & Medicaid Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Acting Administrator Slavitt:

We are writing to inquire about the Center for Medicare & Medicaid Services' (CMS) policy allowing states to move from universal lead screening to a targeted lead screening model. As Ranking Members of the relevant committees of jurisdiction, we have the responsibility and privilege of protecting the rights of the more than 70 million individuals who receive health care under Medicaid and CHIP, including over 43 million children.

In light of that responsibility, and the recent lead poisoning crisis in the Flint community, we ask that you provide us with information on the Medicaid lead screening policy initiated by CMS in 2012. Moreover, we also urge you to work broadly within the agency and with state partners to identify and support opportunities to improve lead screening adherence and identify lead abatement activities.

As you know, lead exposure can cause serious damage to the heart, kidneys, reproductive system, brain and central nervous system.¹ Lead is particularly harmful to the developing brains and nervous systems of young children—even relatively low levels of exposure are associated with irreversible neurologic damage and the development of behavioral disorders.²

Unfortunately, the incident in Flint is not isolated. The problem of significantly elevated blood lead levels in children is pervasive, adversely affecting far too many of our communities nationwide. Data collected by the Centers for Disease Control and Prevention (CDC) shows that over 40 percent of the states that reported lead test results in 2014 have even higher rates of lead poisoning among children than Flint.³ It is worth noting that only 27 states (including

¹ Centers for Disease Control and Prevention, *Very High Blood Levels Among Adults—United States, 2002-2011*, Morbidity and Mortality Weekly Report (Nov. 29, 2013).

² Centers for Disease Control and Prevention, *Educational Interventions for Children Affected by Lead* (Apr. 2015) (online at www.cdc.gov/nceh/lead/publications/Educational_Interventions_Children_Affected_by_Lead.pdf).

³ Centers for Disease Control and Prevention, *Number of Children Tested and Confirmed BLL's ≥ 10 $\mu\text{g}/\text{dL}$ by State, Year, and BLL Group, Children < 72 Months Old* (online at www.cdc.gov/nceh/lead/data/Website_StateConfirmedByYear_1997_2014_01112016.htm).

Washington, D.C.) reported childhood blood lead surveillance results to the CDC's national database for 2014, the most recent statistical set available.

Historically, the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) benefit in Medicaid required universal blood level screening for lead in children at 12 and 24 months of age.⁴ However, CMS changed this policy in 2012 to align with an updated Centers for Disease Control and Prevention (CDC) recommendation calling for a targeted approach for screening Medicaid-eligible children in States where sufficient data exists to support discontinuing universal screening of all Medicaid eligible individuals.⁵ At the time of this policy's release, CMS also noted that the agency would "...be increasing our efforts to ensure that Medicaid eligible children who need to be screened for lead poisoning receive the necessary blood lead screening test."⁶

While only one state thus far has been granted a waiver to move from universal to targeted screening, we strongly believe that, in light of the Flint crisis, it is important to closely review the transparency, ongoing reporting, and evaluation of such waivers. To assist in our inquiry, we ask that you provide the following information, as well as a briefing on your efforts to oversee blood lead level screening in the Medicaid program generally:

1. Please provide an overview on the process for granting waivers from the universal screening requirement, as well as any relevant programmatic documents pertaining to the waiver process.
 - a. What data are State Medicaid agencies required to submit to move to a targeted lead screening approach?
 - b. How do CMS and CDC evaluate whether a state's proposed transition to a targeted screening approach will improve the state's efforts to identify children with high risk for lead exposure?
 - c. Once a state has been granted a waiver to move to targeted screening, what additional documentation is required to be submitted to CMS and CDC to demonstrate the state's ongoing efforts to improve targeting of high risk children?

⁴ Department of Health and Human Services, Centers for Medicare and Medicaid Services, EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (June 2014) (online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf).

⁵ Department of Health and Human Services, Center for Medicaid, CHIP and Survey & Certification, *Informational Bulletin: Medicaid Lead Screening and EQRO protocols* (March 30, 2012) (online at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-30-12.pdf>).

⁶ *Id.*

- d. How are State Medicaid Agencies required to evaluate whether the targeted screening approach has in fact improved the state's ability to reach children at high risk for lead exposure?
2. State efforts to screen Medicaid-eligible children remain inadequate.⁷ For instance, a recent Reuters investigation that reviewed data in nearly a dozen states found that just 41 percent of Medicaid-enrolled one and two year olds had been tested as required.⁸ CMS indicated its intention in 2012 to ensure that Medicaid-eligible children are actually receiving the regular blood lead screenings to which they are entitled.
 - a. Please provide a detailed update on actions CMS has taken to ensure that state partners are using all available resources to fulfill their requirements to screen Medicaid-eligible children and ultimately to eradicate childhood lead exposure.
 - b. How does CMS perform oversight of state Medicaid agencies in charge of implementing blood lead testing of at-risk children?
 - c. What are some best practices for targeted and/or universal lead screening for Medicaid-eligible children? What is CMS doing to encourage states to adopt those best practices?
 - d. The Reuters investigation cited three states—Kansas, Utah, and Alaska—whose health officials indicated that their state Medicaid programs do not require blood lead level testing or do not recognize the federal testing mandate.⁹ Has CMS exempted these states from the universal blood lead level screening requirement? If not, please explain whether these states are out of compliance with federal mandates and whether CMS has any plans to address the non-compliance.
 3. The current version of the CMS State Medicaid Manual establishes that a blood lead level equal to or greater than 10 µg/dL can trigger patient management and treatment protocols, including follow up blood tests and an investigation of the potential source

⁷ See, e.g., Statement of Joan Alker, Executive Director of the Georgetown University Center for Children and Families, Hearing on “The Flint Water Crisis: Impacts and Lessons Learned,” House Committee on Energy and Commerce (Apr. 13, 2016); National Health Law Program, *Response to the New Proposed Policies for Screening Children Enrolled in Medicaid for Elevated Blood Lead Levels* (June 12, 2012) (online at www.healthlaw.org/about/staff/wayne-turner/all-publications/reponse-to-the-new-proposed-policies-for-screening-children-enrolled-in-medicaid-for-elevated-blood-lead-levels#.Vzy0nU3mqYk).

⁸ *Unsafe at Any Level*, Reuters (June 9, 2016) (www.reuters.com/investigates/special-report/lead-poisoning-testing-gaps).

⁹ *Id.*

of lead.¹⁰ However, in 2012 the CDC updated its recommendations on children's blood lead levels to set a reference level of 5 µg/dL to identify children with elevated blood lead levels.¹¹

- a. Does CMS have any plans to update the State Medicaid Manual to reflect CDC's recommendation that the reference level for elevated blood lead be set at 5 µg/dL? If not, please provide an explanation.

The situation in Flint is nothing short of a crisis, but too many of our communities nationwide are also struggling with dangerously elevated lead levels that can and should be avoided. We look forward to continuing to work with you to ensure that in Flint—and elsewhere—no individual faces the devastating and irreversible consequences of lead poisoning.

Thank you for your prompt attention to this matter.

Sincerely,



Frank Pallone, Jr.
Ranking Member
House Energy & Commerce Committee



Ron Wyden
Ranking Member
Senate Finance Committee

cc. Victoria Wachino, Director, CMS Center for Medicaid and CHIP Services

¹⁰ Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Manual § 5123.2.

¹¹ Centers for Disease Control and Prevention, *Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in "Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention"* (June 2012) (online at http://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf).