

Questions for the CDC related to Medicaid Screening Policy Change

1. What will be the process for implementing the recommendation discussed in the article? What opportunities are there, formal or informal, for interested parties to provide comment or suggestion to CDC and CMS? Will it require a formal regulatory change? What is the mechanism by which CMS will issue a change to the State Medicaid Manual or issue a letter to the State Medicaid Director? Does a state have to specifically request a waiver?
2. CDC discusses national data related to difference in EBL rates by Medicaid status and discusses some state data that shows both Medicaid and non-Medicaid rates are falling. Does CDC have state specific data on the difference in EBL rates between Medicaid & non-Medicaid Status? If so, can you provide it?
3. Who did the CDC discuss this plan with prior to issuing the recommendation? Was any outreach made to state/local grantees and partners? Was outreach held with local Medicaid Authorities? Was AAP consulted?
4. CDC notes that "...even BLLs $<10 \mu\text{g/dL}$ can result in decreased cognitive function, developmental delays, and behavior problems." However, the framework for the screening policy is discussed in terms of EBL. While EBL is not actually numerically defined in the article, based on the percent of children with an EBL reported, CDC is using 10 as the threshold. Does CDC intend to evaluate the disparity between Medicaid and non-Medicaid populations using only the threshold of 10? Does CDC have data or information on the possible differences in BLL rates by Medicaid status using thresholds <10 ? In other words, does CDC have data to support the idea that a lack of a significant difference in the rate of children with BLLs ≥ 10 also means there is a lack of a significant difference in the rates of children with BLLs ≥ 5 , ≥ 1 , or lack of a significant difference in average blood lead levels?
5. What data sources will CDC use to determine whether or not there is a difference between the Medicaid and Non-Medicaid populations? Will it be NHANES, HEDIS, State Surveillance, or some combination? What requirements will CDC have for the quality and representativeness of this data? In other words, if the screening rates for the Medicaid and/or non-Medicaid population are low, what assurances will CDC require that the data is truly representative of the entire Medicaid or non-Medicaid population?
6. Will CDC/CMS consider the difference between Medicaid-Eligible and the general population, or just Medicaid-Enrolled and the general population? Are there substantial variations in EBL rates between the enrolled and eligible populations?
7. Will states have to have a targeted screening plan for Medicaid children approved prior to being released from the universal screening requirement? If so, who will approve the plans?

8. Has CDC and CMS had any discussions about reinvesting the cost savings from moving to a targeted screening plan?
9. How will CDC/CMS measure compliance with the targeted screening plans put in place with the states? Particularly if the targeted screening plan calls for using questionnaires such as whether or not the child has a sibling with an EBL, or whether or not the family has consumed informally imported food items, how will CDC determine the denominator of children who should be tested in accordance with the plan?
10. What enforcement actions will CDC/CMS be able to take if a state Medicaid program fails to ensure children are screened in accordance with the state plan? Will the removal of the requirement from the State Medicaid Manual limit the ability of public interest attorneys from suing State Medicaid Agencies for failing to comply with the targeted screening plan?
11. Is there the opportunity to add recommendations to federal guidance for creating state specific plans? Did CDC consider adding exposure to recent renovation activity or residing in a residence with recent code violations as potential criteria for having to be screened?
12. Has CDC/CMS considered whether or not this policy has impacts in states where there remains a disparity? In other words, are there unintended consequences to this policy, such as doctors generally believing lead is not a problem, not associating Medicaid status as a risk factor, etc? Will it undo the hard work in many localities to increase awareness of screening requirements and importance of Pb?
13. Has CDC/CMS considered the impact of a local-targeted screening plan on doctor's offices and the amount of time it would take to implement a questionnaire or other risk assessment method? Do doctors have enough time during a well-child visit to ask/determine all of the factors listed in CDC's model guidance? How much time does that take?
14. What impact will this change have on the amount of BLL surveillance data available to states and localities? Will it impact state/local ability to track a broader range of lead exposure, such as children with BLLs <10?
15. Given the broad non-compliance with the current universal standard, is this not rewarding bad behavior? Why would doctors who can't comply with the mandate of screening everyone on Medicaid be able to comply with more complicated screening criteria?
16. Is this part of a systematic effort to dissemble lead poisoning prevention programs or dissemble the blood lead surveillance system, or otherwise wind-down lead as being a public health concern in light of the 2010 goal or other basis?