CAHP IMPLEMENTATION GUIDELINE

AB 2276 (Reyes)
Chapter 216, Statutes of 2020

As a service to our members, the California Association of Health Plans produces guidelines designed to assist in the interpretation and implementation of new laws, and to promote full compliance with those laws. This document, however, is not intended to be authoritative. Any questions about official interpretations of the law should be directed to the appropriate state regulatory agency such as the Department of Managed Health Care or the Department of Health Care Services, as well as your legal counsel.

CHILDHOOD LEAD POISONING: SCREENING AND PREVENTION

BACKGROUND

Assembly Bill 2276 was introduced by Assemblymember Eloise Gomez Reyes (D-San Bernadino) and co-sponsored by the Environmental Working Group, Coalition of Welfare Rights Organizations and the Western Center on Law and Poverty. This bill was also supported by a broad group of health care consumers and environmental organizations. Initially, this bill was part of a five-bill package that was introduced in response to the California State Auditor's Report titled, *"Childhood Lead Levels: Millions of Children in Medi-Cal Have Not Received Required Testing for Lead Poisoning."*

Following the release of this report in January, the Assembly Environmental Safety and Toxic Materials Committee, Senate Environmental Quality Committee, Assembly Health Committee, Senate Health Committee and the Joint Legislative Audit Committee held a joint hearing in March to discuss the implementation of the auditor's recommendations with various stakeholders.

However, due to the COVID-19 pandemic, the bill package was eventually condensed into one bill: AB 2276. This bill was amended several times throughout the legislative process, with varying requirements shifted around from the Department of Health Care Services (DHCS) and Medi-Cal Managed Care Plans (MMCPs). CAHP did not take a position on this bill; however we worked with stakeholders to ensure that this bill aligned with the substantial efforts DHCS had already undertaken related to the implementation of the State Auditor's report.

Ultimately, AB 2276 requires a contract between DHCS and MMCPs to require the plan to identify, on a quarterly basis, every enrollee who is a child without a record of completing the blood lead screening tests required pursuant to state regulation, and to remind the contracting network health care provider responsible for performing the periodic health assessment of the child enrollee pursuant to state regulation of the requirement to perform required blood lead screening tests for that child, and the requirement to provide oral or written anticipatory guidance to a parent or guardian of the child, including at a minimum, the information that children may be harmed by exposure to lead.

This bill also requires DHCS to develop and implement procedures, and requires, as part of these procedures, DHCS to require a MCMC plan to maintain a record of all child enrollees six years of age or younger who have missed a required blood lead screening and identify the age at which the

required blood lead screenings were missed, including which children are without any record of a completed blood lead screening at each age, and provide that record to DHCS annually and upon request for auditing and compliance purposes.

Lastly, this bill requires the MCMC plan, if the child enrollee, or the child enrollee's parent, guardian, or authorized representative refuses a required blood lead screening test, to ensure a statement of voluntary refusal is signed by the child enrollee, if an emancipated minor, or by the child enrollee's parent, guardian, or authorized representative, and is documented in the child enrollee's medical record.

REQUIREMENTS

Amends Section 105285 of, and adds Section 105301 to the Health and Safety Code, and adds Section 14197.08 to the Welfare and Institutions Code, relating to public health.

Specifically, AB 2276 does the following:

1) Adds to the determination of risk factors to be considered by health care providers evaluating children at risk of lead poisoning, the following:

a) A child's residency in or visit to a foreign country;
b) A child's residency in a high-risk ZIP Code;
c) A child who has a sibling or playmate with lead poisoning;
d) The likelihood of a child placing nonfood items in the mouth;
e) A child's proximity to current or former lead-producing facilities; and,
f) The likelihood of a child using food, medicine, or dishes from other countries.

2) Requires regulations to be developed by January 1, 2021 in consultation with medical experts, environmental experts, appropriate professional organizations, the public, and others as determined by DPH.

3) Requires DPH to update its formula for allocating funds to any local agency that contracts with DPH to administer CLPPP to ensure that funds are allocated equitably and commensurate with the level of services needed to provide to children with elevated blood levels, and to revise funding allocations before each contract cycle. Requires DPH to take into account the most recent data for the number of children with elevated blood lead levels in each jurisdiction when revising the allocation formula.

4) Defines "elevated blood levels" as a blood lead level that is no higher than the blood lead reference value as specified in the most recent guidelines issued by CDC.

5) Requires the EPSDT benefit for Medi-Cal to include the following goals:

a) Every child at risk of lead exposure receives blood lead screening tests, consistent with existing law;
b) Every child who is eligible for services under the Medi-Cal program receives blood lead screening tests at 12 and 24 months of age, consistent with existing regulations; and,
c) Every child, between two and six years of age, who is eligible for services under the Medi-Cal program, and for whom there is no record of a previous blood lead screening test,

receives at least one blood lead screening test pursuant to the most recent guidelines published by the CDC.

6) Requires DHCS to annually post on its Medi-Cal dashboards on its website a report detailing DHCS' progress toward the goals specified in 5) above. Requires the report to include the number of Medi-Cal beneficiaries in each county who have and have not received blood lead screening tests, identified by the following age groups:

a) Newborn to one year of age, inclusive;
b) One year and one day to two years of age, inclusive; and,
c) Two years and one day to six years of age, inclusive.

7) Requires DHCS to ensure the following for a Medi-Cal beneficiary who is a child, consistent with existing regulations:

a) A child receives a blood lead screening test at 12 and 24 months of age; and,
b) A child between two and six years of age, who does not have a record of a previous blood lead screening test, receives at least one blood lead screening.

8) Requires a Medi-Cal managed care plan (MCP), in order to comply with blood lead screening test requirements, to do all of the following:

a) Identify, on a quarterly basis, every beneficiary six years of age or younger that has missed a required blood lead screening and identify the age at which the required blood lead screenings were missed, including which children are without any record of a completed blood lead screening at each age;
b) Notify the child's health care provider when the child misses a required blood lead screening test. Requires the notification to be sent within 30 days of the missed test;
c) Report data to DHCS on the number of children six years of age and young, by each age, who have received a blood lead screening test;
d) Require its contracting health care providers who are responsible for performing a periodic health assessment of a child to test each child, consistent with state and federal law, regulations, and DHCS's Blood Lead Test and Anticipatory Guidance guidelines;
e) Notify its contracting health care providers of the requirement to perform periodic child health assessments and blood led tests;

9) Requires the contract between DHCS and a Medi-Cal MCP to include the requirements of 8) above.

COMPLIANCE DATES

Medi-Cal Managed Care Plans are required to comply with the provisions of this new law by January 1, 2021.

IMPLEMENTATION ISSUES

AB 2276 applies to the Medi-Cal program and requires the California Department of Public Health (CDPH) to develop regulations. On September 29, the California Department of Health Care Services (DHCS) released a companion *All Plan Letter (APL)20-016: Blood Lead Screening of*

Young Children to provide requirements for blood lead screening tests and associated monitoring and reporting for Medi-Cal managed care health plans (MCPs). The APL supersedes APL 18-017.

AB 2276 requires that children enrolled in Medi-Cal must have blood lead screenings at the ages of 12 months and 24 months. This requirement has been in place in California Code of Regulations Title 17 Rule 37100 for children in public-funded program. The standard of care for commercial does not require blood lead screenings except when a provider determines that a child might be at risk for lead poisoning.

In cases where a parent or adult caregiver refuses to provide consent for the blood lead screenings, providers must obtain a signed refusal and enter the signed refusal in the child's medical record. AB 2276 allows a provider to document in the medical record if a parent/caregiver declines to provide a signed refusal. The DHCS APL allows providers a bit more flexibility to document a parent/caregiver's refusal without a signed statement if the provider is not able to obtain a signed statement, as might occur due to a telehealth encounter.

AB 2276 will also require MCPs to identify, on a quarterly basis, children under age 6 who are missing a required blood lead screening. MCPs are required to bring the missing blood lead screenings to the attention of providers and require providers to follow up with the respective families.

DHCS will likely develop a standard reporting template for the quarterly submissions from MCPs.

Neither AB 2276 nor the DHCS APL addresses any of the following:

- Instances where a child may be missing the blood lead screenings because the child was enrolled in private insurance during early childhood and blood lead screenings are not mandatory for children enrolled in private insurance
- Instances where a parent/caregiver did not explicitly refuse the screening, but just does not follow up with getting the blood lead screening done at a lab
- For purposes of signed refusal, is each screening considered separately?
    - If a parent/caregiver refuses to the screening at 12 months, can that refusal also apply to the 24-month screening?
    - Do providers have to document the refusal for each screening separately?
- Data sharing between providers and managed care plans so that children with refusals on record are not repeatedly identified as missing screenings
- The level of manual effort that may be required by providers to compile the data on refusals for reporting purposes. While there is an existing requirement to document refusals, the existing requirement does not require reporting. Extracting data on refusals may require manual chart reviews for some providers who do not have this data stored in an easily reportable format

Additional concerns related to data sharing and sanctions are outlined below.

Data Sharing

- Standing up the reporting, analysis and storage of the data, as well as the data submission to DHCS will require resources and system configurations.

- There are not streamlined processes in place today for member records to move between provider organizations or between health plans. In most counties, Medi-Cal members can change plans at any time. If a member changes plans, the member's historical encounter data does not follow the member to the new plans. If a child is enrolled in Plan A and misses her blood lead screenings and then moves to Plan B, there is concern that Plan B will not know whether the member has or has not had blood lead screenings.
- In the absence of processes and systems to allow historical encounters to follow a member, it's not clear how a Plan will know whether a child who comes to the Plan at the age of 7 had a blood lead screening at 12 and 24 months while enrolled in a previous plan. If the provider has the blood lead screening documented in the medical record, the provider may be able to validate the data point at the plan's request, but that is likely a manual effort. Hence, a full medical record review may be required for all members (per age range) that do not have a blood lead screening found in claims/encounter data; this is the only way MCPs can assess information that does not have a CPT code, such as anticipatory guidance and refusals.
- Quarterly reporting of data requires timely data sharing between providers and MCPs and subcontracted plans with primary plans. The documentation of a signed refusal in a medical record is not likely to be an automated function, so reporting which of the "missing" blood lead screens are signed refusals, versus were not required at the age due to different standards versus are truly missing requires that data to be flagged and easily extractable. Since there has historically been no reason to track these differentiations previously, it is likely the systems do not exist to support this today. The reporting starts Q1 of 2021, but is not limited to children who turn 12 months on or after 1/1/21. Thus, reporting will have a look-back period of up to 6 years for which this granularity of data does not exist.

Sanctions

- AB 2276 authorized DHCS to impose sanctions on MCPs who are found to be in violation of the requirements
- The DHCS companion APL states DHCS will use encounter data and managed care quarterly reports to monitor compliance, but there is no guidance on what is considered a violation. Given that the standards are different between types of coverage (commercial vs. Medi-Cal), there are concerns that MCPs will be found to be in violation for missed screenings for children who may have been under other coverage in their early years and subject to a different screening standard. Additionally, Medi-Cal members in most counties can change plans at any time. There is concern that a current MCP could be held accountable for the absence of screenings that occurred when the member was enrolled in a different plan or with a provider in a different network.
- In the absence of clear guidance on what will be the threshold for noncompliance, there is concern that sanctions may be levied by DHCS as a show of enforcement, but without clear basis.
- Neither the statute nor the APL limit the reporting to new blood lead screenings conducted on or after January 1, 2021. Since there was no requirement to track blood lead screenings historically for reporting purposes, there is concern DHCS could impose sanctions for "missing" screenings going back several years.

If you have any questions regarding this document, please contact Jedd Hampton at 916-552-2910.