



Strategies to Improve Medicaid Screening and Treatment for Lead Poisoning

By Anne M. Wengrovitz and Manjusha P. Kulkarni

Anne M. Wengrovitz
Health Policy Consultant

Alliance for Healthy Homes
4949 Little Falls Road
Arlington, VA 22207
703.362.1567
awengrovitz@attglobal.net

Manjusha P. Kulkarni
Staff Attorney

National Health Law Program
2639 S. La Cienega Blvd.
Los Angeles, CA 90034
310.204.6010
kulkarni@healthlaw.org

In the United States today a health problem, lead poisoning, disproportionately affects children served by Medicaid. Despite this widely acknowledged reality, most Medicaid children have yet to benefit from the full range of screening, diagnostic, and treatment services potentially available to them. Here we review current Medicaid policy for lead screening and follow-up care and offer ideas about legal and advocacy strategies to improve health care services for Medicaid children at risk of lead poisoning.

Lead Poisoning

The adverse health effects of lead on humans have been recognized for centuries.¹ Decades of scientific research show that the longer lead is studied, the more types of health effects are documented. As public health measures result in progressively lower population blood lead levels, scientists can detect increasingly subtle effects hitherto impossible to measure against higher background levels.² One of the ironies of lead poisoning is that the better we do, the worse off we find that we were initially.

¹National Academy of Sciences, *Measuring Lead Exposure in Infants, Children, and Other Sensitive Populations* (1993).

²*Id.*; Richard L. Canfield et al., *Intellectual Impairment in Children with Blood Lead Concentrations Below 10µg per Deciliter*, 345 *NEW ENGLAND JOURNAL OF MEDICINE* 1517–26 (2003).

Health Effects of Lead Exposure. Lead is a heavy metal used in many materials and products worldwide. Lead affects practically all systems within the body.³ Very high levels of lead exposure can cause coma, seizures, and even death, but such high levels are now rare in the United States.⁴ U.S. children are more likely to experience chronic, low-level exposure associated with reduced IQ, distractibility, hyperactivity, reduced stature, reading problems, and other health and behavior problems.⁵

More harmful to young children than to adults, lead is easily absorbed into children's growing bodies; lead interferes with the rapidly developing brain and other organs of young children; and children's behavior may expose them to relatively more environmental lead dust.⁶ Very young children (1 or 2 years old) are thought to be especially vulnerable to the effects of lead.⁷ Pregnant women who are exposed to lead can expose the unborn fetus because lead ingested by the mother can cross the placenta.⁸

Lead is widespread in the environment in paint, dust, soil, water, air, and food, primarily from products (such as residential lead-based paint and leaded gasoline) that are no longer used in the United States.⁹ At present, young children are most likely to be poisoned by ingesting lead dust from lead-based paint in older homes in poor condition,

or sometimes by lead dust from a sanding, repainting, or renovation project in an older house.¹⁰ Very young children (1 or 2 years old) are most likely to be poisoned because of normal hand-to-mouth activity after getting lead dust on their hands and toys.¹¹ However, some U.S. children are lead-poisoned through exposure to lead in consumer products that slip through the regulatory control system or are imported through informal channels. For example, foods, cosmetics, home remedies, pottery, and consumer products manufactured overseas have been linked to lead exposure.¹²



³Centers for Disease Control and Prevention, Preventing Lead Poisoning in Young Children (1991).

⁴Centers for Disease Control and Prevention, Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials (1997).

⁵*Id.*; Centers for Disease Control and Prevention, Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention 42, 80–81 (2002); Bruce P. Lanphear et al., *Cognitive Deficits Associated with Blood Lead Concentrations <10 µg/dL in U.S. Children and Adolescents*, 115 PUBLIC HEALTH REPORTS 521–29 (2000).

⁶David C. Bellinger, *Lead*, 113 PEDIATRICS 1016–22 (2004).

⁷Centers for Disease Control and Prevention, Managing, *supra* note 5.

⁸NATIONAL ACADEMY OF SCIENCES, *supra* note 1.

⁹Centers for Disease Control and Prevention, *supra* note 4.

¹⁰*Id.*

¹¹*Id.*

¹²Centers for Disease Control and Prevention, *Lead Poisoning Associated with Imported Candy and Powdered Food Coloring—California and Michigan* 47 MORBIDITY AND MORTALITY WEEKLY REPORT 1041–43 (1998); U.S. Consumer Product Safety Commission, Interim Enforcement Policy for Children's Metal Jewelry Containing Lead (2000), www.cpsc.gov/businfo/pbjewelgd.pdf; Centers for Disease Control and Prevention, *Lead Poisoning Associated with Use of Traditional Ethnic Remedies—United States* 42 MORBIDITY AND MORTALITY WEEKLY REPORT 521–24 (1993).

A blood test is the only way to know if a child is lead-poisoned because low-level lead poisoning is not accompanied by distinct clinical symptoms. Severely poisoned children may be treated with chelation drugs, which may reduce the level of lead in the body without completely eliminating the lead.¹³ Most importantly, protect a lead-poisoned child from further exposure to lead.¹⁴

Elevated Blood Lead Levels Among U.S. Children. While blood lead levels in the U.S. population have been declining since the late 1970s, significant numbers of U.S. children are still identified each year with elevated blood lead levels.¹⁵ According to the most recent estimates from the Centers for Disease Control and Prevention's national health and nutrition examination survey, about 434,000 or 2.2 percent of children from 1 to 5 years old had blood lead levels of 10 µg/dL or greater in 1999–2000.¹⁶ Survey data from 1991–1994 show that certain population subgroups are at increased risk of elevated blood lead levels: children who are low-income or African American or Hispanic or who reside in older housing or in major metropolitan areas.¹⁷

Surveillance data from states and cities show geographic variability. For exam-

ple, screening data from nineteen states from 1996 to 1998 at the county level vary dramatically from place to place. Within a single state, 27.3 percent of tested children had elevated blood lead levels in one county but only 1.3 percent in another.¹⁸ Data by zip code on blood lead show that a minority of zip codes account for a majority of identified cases of elevated blood lead levels.¹⁹ A more recent analysis of state data on blood lead screening shows that five states and New York City account for 54 percent of the confirmed elevated blood lead levels reported to the Centers for Disease Control and Prevention in 2001.²⁰

Elevated Risk of Medicaid Population. At the national level, data consistently show that, as a group, young children enrolled in or eligible for Medicaid are at increased risk for lead exposure. A 1998 analysis by the U.S. Government Accountability Office (formerly known as the General Accounting Office) found that Medicaid children accounted for 60 percent of U.S. children with elevated blood lead levels at or above 10 g/dL and at least 83 percent of children had blood lead levels greater than or equal to 20 g/dL.²¹ A subsequent analysis of the same data found an even more striking association, estimating that up to 93 percent of children with elevated blood lead levels greater than or equal to 20 were

¹³Centers for Disease Control and Prevention, Managing, *supra* note 5.

¹⁴*Id.*

¹⁵Elevated blood lead levels are defined as those at or above 10 µg/dL. This "level of concern" was established by the Centers for Disease Control and Prevention in 1991 as a public health action level but is commonly referred to as "lead poisoning." Some argue that there is no safe threshold and therefore the definition should be reduced to a lower level. Others argue that a "lead poisoning" definition should be reserved for higher levels requiring ongoing clinical care.

¹⁶The 95 percent confidence intervals for these estimates are 189,000–846,000 and 1.0 - 4.3 percent, respectively. Pamela A. Meyer et al., Surveillance for Elevated Blood Lead Levels Among Children—United States, 1997–2000 in *Surveillance Summaries*, 52 MORBIDITY AND MORTALITY WEEKLY REPORT, Sept. 12, 2003, at 1–2.

¹⁷The sample sizes for the Centers for Disease Control and Prevention's national health and nutrition examination surveys conducted in 1999 and 2000 were not large enough to develop reliable updated estimates for elevated blood lead levels among these population subgroups.

Centers for Disease Control and Prevention, Update: Blood Lead Levels—United States, 1991–1994, 46 MORBIDITY AND MORTALITY WEEKLY REPORT 141–46. (1997).

¹⁸Centers for Disease Control and Prevention, Blood Lead Levels in Young Children—United States and Selected States, 1996–1999, 49 MORBIDITY AND MORTALITY WEEKLY REPORT, Dec. 22, 2000, at 1133–37.

¹⁹Mary Jean Brown et al., Alliance to End Childhood Lead Poisoning, Small Area Analysis of Risk for Childhood Lead Poisoning (2001), www.afhh.org/res/res_pubs/saa.pdf.

²⁰Meyer et al., *supra* note 16.

²¹U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICAID: ELEVATED BLOOD LEAD LEVELS IN CHILDREN (1998); *id.*, LEAD POISONING: FEDERAL HEALTH CARE PROGRAMS ARE NOT EFFECTIVELY REACHING AT RISK CHILDREN (1998).

Medicaid-eligible.²² More recent data from screenings for blood lead levels continue to demonstrate the increased risk for lead poisoning of Medicaid children.²³ In Minnesota a state review of cases of elevated blood lead levels identified between 1995 and 1998 found that 72 percent were enrolled in Minnesota's Medicaid program (known as the Minnesota Health Care Programs).²⁴ In Wisconsin 85 percent of children who were diagnosed with lead poisoning in 2002 were enrolled in Medicaid.²⁵

EPSDT Lead Requirements

Medicaid is a cooperatively funded federal and state program whose purpose is to enable each state to provide medical assistance to low-income families with children, the elderly, and people with disabilities.²⁶ Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program entitles children to comprehensive preventive health care and necessary diagnosis and treatment.²⁷ The EPSDT statutes make states responsible for providing medical checkups; vision, hearing, and dental services; and necessary

diagnostic and treatment services to all eligible children under 21 years.

Screening. In terms of services related to elevated blood lead levels, the federal statute requires states to include—as part of the medical screen for blood lead levels as indicated by age and risk factors—health education and anticipatory guidance to the child and family regarding lead poisoning and medically necessary treatment services.²⁸

The Centers for Medicare and Medicaid Services (CMS), the division of the U.S. Department of Health and Human Services (HHS) responsible for administering the Medicaid program, addresses lead screening in its *State Medicaid Manual*, the primary federal guidance document. The manual requires that (1) all children receive a blood lead test at 12 months and 24 months of age; (2) children between the ages of 36 months and 72 months receive a blood lead test if they have not been previously tested; and (3) a lead blood test be used when screening Medicaid-eligible children, and if a capillary specimen shows a level of 10 µg/dL or greater, the result must be confirmed by using a venous blood sample.²⁹

²²Rachel B. Kaufmann et al., *Elevated Blood Lead Levels and Blood Lead Screening Among U.S. Children Aged One to Five Years: 1988–1994*, 106 *PEDIATRICS* E79 (Dec. 2000).

²³A condition of the Centers for Disease Control and Prevention's current grants to states and cities for childhood lead-poisoning prevention is the development of a jurisdictionwide strategic plan for lead elimination by 2010. At writing, most jurisdictions have finished their plans and posted them on websites. For advocates, these plans are proving to be a good source of easily accessible data and program descriptions. A list of the plans containing hyperlinks is posted and maintained by the Centers for Disease Control and Prevention at www.cdc.gov/nceh/lead/Strategic%20Elim%20Plans/strategicplans.htm.

²⁴Susan E. Castellano et al., *Minnesota Department of Health, Elevated Blood Lead Levels in Minnesota and the Medicaid Population (2002)* www.health.state.mn.us/divs/eh/lead/reports/medicaidleadrpt.pdf.

²⁵Wisconsin Department of Health and Family Services, *Wisconsin Childhood Lead Poisoning Elimination Plan 2010 (2004)*, http://dhfs.wisconsin.gov/lead/EPWV_CLP_Elim_Plan_073004.pdf.

²⁶See 42 U.S.C. § 1396 (2004); while state participation is voluntary, once a state elects to participate, it "must comply with the requirements imposed both by the Act itself and by the Secretary of Health and Human Services." *Schweiker v. Gray Panthers*, 453 U.S. 34, 36–37 (1981); see also *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 500 (1990).

²⁷See 42 U.S.C. §§ 1396a(a)(10)(A), a(a)(43), d(a)(B), d(r) (2004).

²⁸In 1989 Congress amended the Medicaid Act to include the requirement for blood lead assessments. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2263 (1989); see 42 U.S.C. § 1396d(r)(1)(B)(2004); CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *STATE MEDICAID MANUAL* § 5123.2.A (2005) (entitled "Comprehensive Health and Developmental History"). Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) also requires state Medicaid agencies to "arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment." 42 U.S.C. § 1396a(a)(43)(C) (2004).

²⁹CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *STATE MEDICAID MANUAL* § 5123.2 (2005). Earlier versions of the State Medicaid Manual did not require blood lead tests but simply verbal screenings. See HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *STATE MEDICAID MANUAL* § 5123.2D (1992) (explaining that "[p]hysicians providing screening/assessment services under the EPSDT program [should] use their medical judgement [sic] in determining the applicability of the laboratory tests or analyses to be performed"). These 1993 changes came as a result of the *Thompson v. Raiford* settlement agreement that all children from 6 to 72 months of age are considered at risk and must be screened for lead poisoning. The only acceptable laboratory screening test, according to the settlement, was the blood lead test and not the erythrocyte protoporphyrin test.

CMS also issues agency interpretation on lead screenings through its “Dear State Medicaid Director” letters. An April 13, 1998, letter states that all Medicaid-eligible children must be tested at 12 months and 24 months and children between 36 months and 72 months should be tested if for the first time.³⁰ It also asks states to incorporate mandatory screening into managed care services for children.³¹ CMS reiterated these guidelines in an October 22, 1999, Dear State Medicaid Director letter.³² Current Medicaid policy also specifies that “states may not adopt a statewide Plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.”³³

Congress requires states to report annually on EPSDT. Using what is called Form-416, CMS requires that each state annually report, among other data, the number of children eligible for and receiving early and periodic screening and the number of children who were tested for blood lead.³⁴ The form would demonstrate the state’s attainment of participant and screening goals and show trends, patterns, and projections “from

which decisions and recommendations can be made to ensure that eligible children are given the best possible health care.”³⁵

The National Health Law Program, through a Freedom of Information Act request, obtained copies of Form 416 to determine the rates of EPSDT screening and participation rates of children enrolled in Medicaid. Reviewing the data, the organization determined that nationally only 12 percent of children up to 5 years old were tested for blood lead in 1999.³⁶ The number decreased to 11 percent in 2000 and increased back to 12 percent in 2001.³⁷ The state percentages of children who were tested for blood lead in 2001 were also very low; they ranged from below 1 percent for Alaska and Arkansas to a high of 19 percent for Hawaii.³⁸ National survey data support these low compliance rates. The Government Accountability Office, in its 1999 report *Lead Poisoning: Federal Health Programs Are Not Effectively Reaching At-Risk Children*, found that only 18 percent of children in federal health care programs received lead screening services.³⁹ The screening rate of Medicaid-

³⁰Letter from Sally K. Richardson, Director, Health Care Financing Administration, to State Medicaid Directors (April 13, 1998).

³¹*Id.*

³²Letter from Timothy M. Westmoreland, Director, Health Care Financing Administration, to State Medicaid Directors (Oct. 22, 1999), www.cms.hhs.gov/states/letters/smdo2299.asp.

³³CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 5123.2D1 (2005). Since 1997, the Centers for Disease Control and Prevention’s lead-screening guidance has recommended that states review local risk data and develop lead-screening plans targeting children at increased risk for lead poisoning. Some states have incorporated these screening plans into statutes or regulations; other states have simply offered them as advisory information. The Centers for Medicare and Medicaid Services (CMS) subsequently clarified in the State Medicaid Manual that such plans might not require less than the mandated screening for Medicaid children.

³⁴CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, EPSDT SCREENING 416 FORM (1999). A sample form is at www.healthlaw.org/docs/HCFA416.pdf. The requirement to report lead testing was added to the form in 1999.

³⁵Richardson, *supra* note 30, at 1.

³⁶JANE PERKINS ET AL., CHILDREN’S HEALTH UNDER MEDICAID: NATIONAL REVIEW OF EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT 1999–2001 (2004); see also ANNE M. WENGROVITZ, LEAD SCREENING FOR CHILDREN SERVED BY MEDICAID: ARE STATES MEASURING UP? (FORTHCOMING 2005).

³⁷*Id.*

³⁸*Id.* at 33. The National Health Law Program is reviewing data for 2002–2003 and will post the information at www.healthlaw.org.

³⁹U.S. GOVERNMENT ACCOUNTABILITY OFFICE, LEAD POISONING: FEDERAL HEALTH PROGRAMS ARE NOT EFFECTIVELY REACHING AT-RISK CHILDREN 27 (1999).

enrolled children from 1 year old to 5 years old was 19 percent.⁴⁰

Follow-Up Care. The *State Medicaid Manual* also provides guidance on care for children who have elevated blood lead levels.⁴¹ The manual mandates that if the blood lead level is 10 µg/dL or greater, health care providers are to use their professional judgment to determine the course of treatment, including follow-up tests, and “investigations to determine the source of the lead.”⁴² The April 13, 1998, Dear State Medicaid Director letter directs states to cover any medically necessary diagnostic and treatment services, including case management services and a onetime investigation to determine the source of the lead.⁴³ A second Dear State Medicaid Director letter on the subject of lead screenings and treatment services mandates that

states ... cover any follow-up services within the scope of the Federal Medicaid statute, including diagnostic or treatment services determined to be medically necessary. Such services would include both case management services and the one-time investigation to determine the source of lead for children diagnosed with elevated blood lead levels.⁴⁴

While Medicaid reimbursement is available for the health professional’s time and activities during an on-site environmental investigation to determine the source of the lead, Medicaid funds may not pay for testing of environmental substances such as paint or water.⁴⁵

In *Another Link in the Chain*, a report issued by the Alliance to End Childhood Lead Poisoning (now called the Alliance for Healthy Homes) and the National Center for Lead-Safe Housing, states were surveyed about case management services that they provide and environmental investigations that they conduct after a child is found to have an elevated blood lead level.⁴⁶ Forty-eight state programs responded that they provided some type of case management to children with blood lead levels of 20 µg/dL and above.⁴⁷ Approximately two-thirds of states offer case management to children with blood lead levels of 15 µg/dL and higher and about one-fifth of them provide it to children with levels of 10 µg/dL and higher.⁴⁸ Case management services offered by states involve a range of follow-up activities, including calls with health care providers, telephone follow-up with families, and visits to the child’s home.⁴⁹

A majority of states conduct environmental investigation when children show

⁴⁰*Id.* at 28. This rate came from the Health Care Financing Administration’s 1994 and 1995 State Medicaid Resource File, which contains Medicaid fee-for-service information on eligibility, billing claims, and utilization for states participating in the Medicaid Statistical Information System. *Id.*

⁴¹CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 5123.2D1a (2005).

⁴²See *id.* § 4385 (investigations to determine the source of a child’s elevated blood lead level are patient-oriented and therefore covered; however, environmental interventions to remove the lead source are not).

⁴³*Id.*

⁴⁴Westmoreland, *supra* note 32, at 2. Clarifying the meaning of the State Medicaid Manual, CMS Director Timothy Westmoreland explained that if the child had an elevated blood lead level, conducting an investigation to find the source of lead was not optional for a state. Rather, the state was required to undertake an investigation, for which the state could seek federal Medicaid reimbursement.

⁴⁵STATE MEDICAID MANUAL, *supra* note 41, § 5123.2D1a.

⁴⁶ANNE M. GUTHRIE & PAT MCLAINE, ANOTHER LINK IN THE CHAIN, ALLIANCE TO END CHILDHOOD LEAD POISONING AND THE NATIONAL CENTER FOR LEAD-SAFE HOUSING (1999). Case management and environmental investigations described in the report are provided by states through federal and state Medicaid funding as well as state funding for public health programs.

⁴⁷*Id.* at 31.

⁴⁸*Id.*

⁴⁹*Id.* at 35–36.

elevated blood lead levels. Thirty-five states perform environmental investigations when children have lead levels of 20 µg/dL and higher.⁵⁰ Of the thirty-five states, twenty require a single, confirmed blood lead level of 20 µg/dL and higher while thirteen mandate repeated levels of 15 µg/dL and higher.⁵¹

Implications of Medicaid Managed Care

Managed care has been a major vehicle for the delivery of Medicaid services since the late 1980s. As a result, managed care's role in assuring the lead screenings mandated by EPSDT has become increasingly important.

Managed care delivery of health care services offers Medicaid recipients several benefits that they cannot obtain through traditional fee for service. Most notable, managed care provides beneficiaries with "a medical home" through which they can obtain services; that is they can seek referrals to specialists as well as assistance on prescription drugs and other services through a centralized entity—their health plan. Managed care plans may compel providers to perform state and federally mandated services. Properly implemented, managed care can provide children with greater opportunity to obtain age-appropriate periodic lead screenings as well as medically necessary follow-up care from Medicaid providers participating in their health plans.

While managed care does offer the possibility of obtaining needed medical care

through "a medical home," it can simply result in increased bureaucracy through which beneficiaries have to navigate. States have failed to implement adequate mechanisms to ensure that managed care contractors are delivering required preventive care and complying with EPSDT policies.⁵² The failure of states to engage in appropriate monitoring and oversight is due, in part, to the lack of specificity in managed care contracts, especially in terms delineating EPSDT requirements. In several states, federally required EPSDT screenings are not mandated in the Medicaid managed care contracts.⁵³ With little or no mention of lead testing and treatment protocols in managed care contracts, health plans offer providers scant advice on EPSDT mandates; providers who do not understand the extent of their obligations to Medicaid beneficiaries perform well-child examinations, which do not always include blood lead tests.

Litigation as a Strategy to Improve Services

In the past twenty years a number of lawsuits have been brought on behalf of Medicaid beneficiaries challenging the failure of states to provide lead screenings. In *Thompson v. Raiford* Medicaid beneficiaries brought on behalf of all Medicaid-eligible children a nationwide class action lawsuit against the Texas Department of Health Services and HHS to ask the court to order the agencies to implement the Medicaid Act's requirements for blood lead level assessments appropriate for age and risk factors.⁵⁴

⁵⁰*Id.* at 53.

⁵¹*Id.* However, deficiencies have been noted in state policies, including the failure of many states to comply with required coverage of case management and environmental investigation services provided to Medicaid children with elevated blood lead levels. *Id.* See also PAT MCLAINE & JOANNA GAITENS, ANOTHER LINK IN THE CHAIN UPDATE (2001), www.centerforhealthyhousing.org/Link_in_Chain_Update.pdf.

⁵²Jane Perkins & Lourdes A. Rivera, *EPSDT and Managed Care: Do Plans Know What They Are Getting Into?* 28 CLEARINGHOUSE REVIEW 1248, 1252 (March 1995).

⁵³*Id.* (referring to National Academy for State Health Policy, Preliminary Analysis of Issues and Options in Serving Children with Chronic Conditions Through Medicaid Managed Care Plans, Summer 1994, at 3). See also MANJUSHA P. KULKARNI, NATIONAL HEALTH LAW PROGRAM, MANAGED CARE'S IMPACT ON LEAD TESTING OF MEDICAL BENEFICIARIES IN LOS ANGELES COUNTY (2002), www.healthlaw.org.

⁵⁴See *Thompson v. Raiford*, No. 3:92-CV-1539-R, Medicare & Medicaid Guide (CCH) ¶ 41,776 (N.D.Tex., Sept. 24, 1993). See also *Matthews v. Coye*, No. C903620EFL, U.S. Dist. Ct. (N.D. Cal., Oct. 17, 1992) (stipulations for settlement and dismissal without prejudice) (requiring testing, assessment, and monitoring of young children for lead); *Ellis v. Wetherbee*, No. S92-0529 (S.D. Miss. May 1994) (mandating periodic and interperiodic lead testing); *New York City Coalition to End Lead Poisoning v. Koch*, 524 N.Y.S.2d 314 (N.Y. Sup. Ct. 1987) (holding that plaintiffs provided ample evidence that defendants' lead screening program failed to satisfy federal EPSDT requirements, which they were obligated to provide).

The court-approved settlement agreement established federal guidelines for screening Medicaid-eligible children for lead poisoning.⁵⁵

In *Salazar v. District of Columbia* several children brought a lawsuit alleging that the District of Columbia failed to provide or arrange blood lead tests and necessary follow-up diagnosis and treatment as mandated by federal EPSDT requirements.⁵⁶ The court, in finding for the plaintiffs, held that district officials did not ensure that providers of EPSDT services were “qualified and willing to provide EPSDT services,” thereby violating federal regulations.⁵⁷ It also determined that, while the district had EPSDT screening data from managed care plans, the district failed to notify families and arrange for needed corrective treatment for the children.⁵⁸ To ensure the provision of EPSDT services, the court later ordered a special monitor to develop a tracking system to determine if Medicaid-enrolled children received all age-appropriate screens and services as well as necessary follow-up care.⁵⁹ More recently, the Medicaid participating plans in the district were required to submit lead testing and treatment compliance action plans because the court’s orders regarding EPSDT had not been followed.

In 2000 California Medicaid beneficiaries and a number of community-based organizations filed another lawsuit, *Healthy Children Organizing Project v. Department of Health Services*, to force the California Department of Health Services to promulgate regulations based upon the Childhood Lead Poisoning Prevention Act of 1991,

which had created a standard of care for blood lead screening of children under 6 years old.⁶⁰ Emergency regulations issued in October 2000 required targeted screening for Medi-Cal-enrolled children at 12 and 24 months and also anytime between 25 and 72 months if the child had not been screened.⁶¹ While the emergency regulations contained some lead screening guidelines, the California Superior Court determined that they failed to meet the statute’s minimum requirements and ordered the Department of Health Services to file new regulations requiring that all children be evaluated for risk of lead poisoning by health care providers during periodic health assessments, that the children determined to be at risk for lead poisoning be screened, and that the children with lead poisoning receive medically necessary follow-up services.⁶²

Attorneys considering litigation in this area have a few possibilities on behalf of their Medicaid clients. If the children at 12 or 24 months have either obtained EPSDT medical screens without receiving a lead test or received a lead test that indicated an elevated blood lead level without receiving follow-up treatment, the attorney may bring EPSDT claims based upon a failure to provide medical assistance to eligible individuals or a failure to provide EPSDT services or both.⁶³ A state attorney general may bring a lawsuit against a managed care entity for failing to conduct lead tests on children enrolled in the Medicaid managed care plan. Such a case may be brought only if the managed care contract requires lead testing of children or the plan receives prepayment specifically for conducting blood lead tests and the plan and its providers fail to perform the tests.

⁵⁵*Id.* See CENTERS FOR MEDICARE AND MEDICAID SERVICES, *supra* note 28, and accompanying text.

⁵⁶*Salazar v. District of Columbia*, 954 F. Supp. 278 (D.D.C. 1996).

⁵⁷*Id.* at 332 (referring to 42 C.F.R. § 441.61(b)).

⁵⁸*Id.*

⁵⁹See *Salazar v. District of Columbia*, No. CA-93-452 (GK) (D.D.C. Jan. 17, 1997). A consent decree was later issued in the case and remains in effect.

⁶⁰See *Healthy Children Organizing Project v. Department of Health Services*, No. 313012, (Cal. Super. Ct., San Francisco County, June 19, 2000) (complaint).

⁶¹CAL. CODE REGS. tit. 17 § 37100 (2005).

⁶²*Id.*

⁶³42 U.S.C. § 1396a(a)(10), a(a)(43), d(a)(B), or d(r)(2004).

Advocacy and Technical Assistance Strategies to Improve Services

In recent years experts in childhood lead-poisoning prevention have recommended a range of strategies to improve the delivery of lead screening and follow-up services to Medicaid-eligible children.⁶⁴ States have been experimenting with these and other strategies with varying degrees of success. Advocates are finding that agency staff members often express considerable interest in learning about other states' initiatives in this area. Thus advocates may find that giving information and technical assistance on such initiatives to health departments or Medicaid staff responsible for lead screening is a high-yield strategy in the current landscape.

The strategies described here are focused on increasingly motivating health care providers of blood lead screening services. (These providers include individual physicians, traditional group practices, or managed care organizations.) However, the strategies use different triggers to improve provider motivation and ultimately screening performance. They are all based on the premise that the health department or the Medicaid agency or both are willing partners in efforts to improve screening.

- *Communicate risk data clearly.* Some jurisdictions find that health care providers improve their screening performance after receiving clear information on local lead risks. One effective communication tool has been detailed local maps showing lead risk data. For example, the Wisconsin Childhood Lead Poisoning Prevention Program used geographic information systems software to plot elevated blood

lead levels and housing age data spatially.⁶⁵ Though a seemingly simple strategy to present just two risk factors, the maps have proven to be surprisingly powerful in motivating action and raising awareness.⁶⁶

- *Monitor and provide feedback on screening performance.* Many states have been building capacity to link their blood lead surveillance databases with their Medicaid databases.⁶⁷ Such linking makes for strategies for improvements. The state can compare Medicaid enrollment lists with records of tested children and can generate lists of unscreened Medicaid children. The names of children who require screening can then be given to individual health care plans and physicians. This strategy can also be used repeatedly, as in Rhode Island, in a concerted effort to evaluate and improve screening among a particular birth cohort or by an individual managed care plan.⁶⁸ Linking blood lead surveillance and Medicaid databases also makes it possible to give specific information about rates of elevated blood lead levels identified among the patients of individual health plans or physicians and to learn more about exposure patterns among Medicaid children. Such analyses also help state Medicaid agencies achieve more nearly complete and accurate reporting of lead screening on the annual CMS 416 report.
- *Offer financial rewards or penalties.* Some jurisdictions have used money to get the attention of health care providers. In Maine the Primary Care Providers' Incentive Program offers incentives to health care providers for serving Medicaid beneficiaries and for achieving certain screening targets,

⁶⁴Advisory Committee on Childhood Lead Poisoning Prevention, Centers for Disease Control and Prevention, *Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk* 49 MORBIDITY AND MORTALITY WEEKLY REPORT, Dec. 8, 2000.

⁶⁵The Wisconsin maps and descriptive information can be accessed at <http://dhfs.wisconsin.gov/lead/Maps/index.HTM>.

⁶⁶Centers for Disease Control and Prevention, *Building Blocks for Primary Prevention: Protecting Children from Lead-Based Paint Hazards* 168–70 (2005) www.cdc.gov/nceh/lead/Publications/Building%20Blocks%20Print%20Copy.pdf.

⁶⁷*Id.* at 164–67.

⁶⁸Rhode Island Department of Health, *Rhode Island's Plan to Eliminate Childhood Lead Poisoning by 2010*, at 7–8 (2004), www.health.ri.gov/lead/family/eliminationplan.pdf.

including blood lead screening.⁶⁹ In Minnesota both incentives and penalties are employed to help get all at-risk children screened for lead. Health care plans are eligible for incentive payments for improvements in lead-testing rates. Minnesota has begun to withhold 5 percent from contracts between health plans and the Department of Human Services. Specific targets for increasing lead screening in high-risk population groups are a significant part of the measures used to determine how much of the amount withheld may be “earned” back by the plans.⁷⁰

- *Improve environmental response to identified elevated blood lead levels.* A barrier to improved lead screening is the perception (unfounded, we hope) that screening is pointless—no benefit will come to children identified with elevated blood lead levels because no action will occur to protect them from further lead exposure.⁷¹ Besides general efforts to improve the delivery of case management services and communication with physicians, some jurisdictions have launched more aggressive efforts to counter this perception. For example, in Connecticut, a program called Lead Action for Medicaid Primary Prevention seeks to prevent further rises in blood lead levels and more serious damage to children by providing early intervention services to Medicaid children with blood lead levels too low (below 20 ug/dL) to trigger state requirements for abatement and full case management services.⁷² At least two states

(Maine and Massachusetts) have used the discovery of a housing unit with lead hazards, including those identified through environmental investigation associated with poisoned children, to trigger buildingwide hazard assessments in multiunit buildings.⁷³ These assessments may be accompanied by buildingwide blood lead screening of other young children who are occupants. Such broad public health responses reinforce the understanding that screening can lead to effective preventive action.

Pending Issues

Several issues on the horizon are expected to affect policy or delivery of lead-screening services to children enrolled in Medicaid. Perhaps the most obvious of these is whether CMS modifies Medicaid lead-screening requirements. As described here, current CMS policy requires all state Medicaid programs to provide blood lead screening tests to all young children as part of an EPSDT screen.⁷⁴ At a national level this policy is warranted since national data consistently show Medicaid-eligible children to be at increased risk for elevated blood lead levels. However, at least two states believe that blood lead exposure patterns of children in their jurisdictions suggest that universal screening is not an appropriate use of screening resources and have sought permission from CMS to administer blood lead screening tests to Medicaid enrollees selectively instead of universally.⁷⁵ CMS has been considering its response along with a detailed set of recommendations for revising Medicaid screening policy to permit such targeted

⁶⁹Alliance to End Childhood Lead Poisoning, Track, Monitor, and Respond: Three Keys to Better Lead Screening for Children in Medicaid (2001), www.afhh.org/res/res_pubs/lead%20job%202.pdf.

⁷⁰Minnesota Department of Health, Environmental Health Division, Minnesota's Lead Poisoning Prevention Program's Biannual Report to the Legislature 2003), www.health.state.mn.us/divs/eh/lead/reports/legreport2003finaltextonly.pdf.

⁷¹Advisory Committee on Childhood Lead Poisoning Prevention, *supra* note 64.

⁷²Connecticut's program, Lead Action for Medicaid Primary Prevention Program, is at www.dph.state.ct.us/BRS/Lead/Financial/lead_LAMPP.htm; Centers for Disease Control and Prevention, *supra* note 66, at 173–75.

⁷³Centers for Disease Control and Prevention, *supra* note 66, at 176–78.

⁷⁴STATE MEDICAID MANUAL, *supra* note 29; the specific Medicaid requirement has been revised on different occasions. The current policy has been in place since 1998. Previously Medicaid required that a verbal risk assessment questionnaire be used to determine a child's blood lead testing schedule. Note that “screening” now means administration of an actual blood lead test. Some confusion still lingers from the previous policy.

⁷⁵Advisory Committee on Childhood Lead Poisoning Prevention, *supra* note 64.

screening but has not yet granted any waivers or revised its screening policy.⁷⁶

Nevertheless, we predict that continuing declines in populationwide blood lead levels will eventually lead CMS to conclude that universal blood lead screening is no longer justified for every child served by Medicaid and to permit some form of targeted screening. Thus advocates will need to be familiar with the lead-screening policies for individual state Medicaid programs.

A different type of challenge is brewing on the technological horizon. Since 1997, a portable blood lead analysis device, approved by the Food and Drug Administration, has been available for use in delivering “real-time” blood lead screening results.⁷⁷ The major advantage of this device is that it enables on-site blood lead results, triggering immediate follow-up and taking advantage of a teachable moment. However, the device’s use is limited by federal clinical laboratory regulations to certain certified laboratories, and this effectively rules out most physicians’ offices.⁷⁸ The manufacturer has indicated its plans to market a second-generation device specifically designed for use by medical offices and facilities without any special laboratory certification.

Since health departments usually rely on laboratory reports to track screening rates and results, this device can potentially interrupt the flow of current surveillance or claims data about screening services. But since Medicaid managed care organizations rely on contractual arrangements with laboratories for blood lead sample collection and analysis, predicting the impact of such a device is difficult. Assuming that such a device comes into broad use, advocates should be aware that it may improve access to lead screening while decreasing the accuracy and timeliness of surveillance data.

Conclusion

Medicaid-eligible children often face barriers to receiving recommended health care screening and treatment services—barriers such as access to care, changes in eligibility, limited English proficiency, and lack of outreach and transportation—but the environmental nature of lead poisoning poses further challenges to ensuring appropriate service delivery. The genuine progress in reducing blood lead levels across the U.S. population, but particularly in reducing severe symptomatic lead poisoning, has yielded a broad perception that lead poisoning has been eliminated, thus complicating efforts to encourage physicians to do routine blood lead testing. Because prevention and treatment of lead poisoning requires identifying and controlling lead exposure in a child’s environment, physicians cannot merely offer traditional medical interventions such as prescription drugs and surgery. Instead physicians must catalyze but cannot directly provide follow-up care by public health agencies and others to assess and control lead hazards in homes—the most common source of lead exposure. In many communities insufficient financial resources or other systems are in place to ensure that lead hazards are eliminated from the homes of low-income, lead-poisoned children; this may lead health care providers to conclude that screening is pointless since it does not protect the child from further lead exposure.

The burgeoning amount of scientific research in this area, along with some debate and controversy, creates a policy landscape that is continually shifting. Health advocates for children must persist and be creative in their efforts to ensure that state Medicaid programs provide mandated screening and treatment services to the high-risk population groups that they serve.

⁷⁶At the request of former U.S. Department of Health and Human Services (HHS) Secretary Donna Shalala, the federal Advisory Committee on Childhood Lead Poisoning Prevention developed recommendations for how Medicaid lead screening policy might be revised to permit such targeted screening. The recommendations have been pending at HHS since the fall of 2002; as of March 2005, no revisions have been made.

⁷⁷At this writing, the LeadCare by Environmental Sciences Associates, Inc. is the only Food and Drug Administration–approved portable device capable of quantitative blood lead analysis within minutes. Traditional blood lead testing results are not normally available for several days because blood samples are sent to clinical laboratories for analysis.

⁷⁸Advisory Committee on Childhood Lead Poisoning, *supra* note 64.