ACCLPP

Department of Health and Human Services

Advisory Committee on Childhood Lead Poisoning Prevention

September 26, 2002

The Honorable Tommy G. Thompson
Secretary
US Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Recommendations on Lead Screening for Children Eligible for Medicaid

Dear Secretary Thompson:

The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) is pleased to provide to you its recommendation on targeted lead screening for young children eligible for Medicaid services. We appreciate your delaying revisions to Medicaid lead screening policy until we could submit our final recommendations. We hope that you will find our suggested approach to be an asset to national public health practice, while accommodating the practical and programmatic concerns of individual states.

Recommendation for a New Lead Screening Exception (LSE) Option for States

ACCLPP is recommending that HHS permit states to apply for a Lead Screening Exception (LSE), a new option under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). The LSE is intended to improve lead screening services for children who are eligible for Medicaid through strategic, data-based targeting of these services. The goal of the LSE is to encourage states to develop comprehensive approaches that ensure appropriate Medicaid blood lead screening while remaining responsive to local conditions. States that choose this option will be provided flexibility to determine their own approaches in exchange for demonstrating intensified screening among populations they identify as at-risk, on the basis of analysis of data.

To request an LSE, a state would develop a detailed proposal describing screening objectives, proposed screening approach(es), and justification for the proposed approach. State proposals that meet certain parameters (described in the enclosed recommended guidance) would receive objective review as described herein. Within these parameters, states have flexibility to design unique targeting plans. A new Medicaid Lead Screening Peer Review Committee (PRC), primarily comprising experts in epidemiology and lead poisoning would be appointed by the Centers for Disease Control and Prevention (CDC) to review applications. The PRC will recommend approval or denial of individual LSE requests. States that receive an LSE would commit to implementation of their proposed screening plan in lieu of the current EPSDT policy of routine lead

screening for all young children in Medicaid. States without approved LSEs would be required to comply with current EPSDT policy requiring routine lead screening for young children.

The attached document is the ACCLPP recommendation, presented in the form of guidance from the Centers for Medicare and Medicaid Services (CMS) to state Medicaid agencies. Its contents are:

The Foreword, which describes the thinking of the ACCLPP with regard to our recommendation and may be of interest to states as they consider applying for an LSE;

The Introduction, which contains information on recent trends in childhood lead poisoning and findings relevant to the population of young Medicaid beneficiaries;

Part 1, which describes the process we recommend for states to use in requesting an LSE and for HHS to use in reviewing, awarding, and overseeing LSEs, including suggested roles for CMS and CDC;

Part 2, which describes our recommendations for required elements of state LSE applications;

Part 3, which recommends a set of measures for monitoring state performance on an ongoing basis and for systematic evaluation of the impact of LSEs; and,

Appendices. Four appendices accompany the recommendations. Appendices A, B, and C present three different models of state targeting strategies that exemplify the kind of approaches that we envision. Appendix A is presented as a complete request for an LSE from a fictitious state; Appendices B and C are abbreviated outlines of requests, also from fictitious states. We hope that these models will provide useful guidance on targeting and demonstrate the usefulness of the application format that we are recommending. States may use these strategies, alone or in combination, or propose others. For the convenience of states, Appendix D provides a list of resources on targeting lead screening and related issues. We recommend that Appendix D initially be provided as a written document, and be maintained for future reference on the CDC web site as a "living document" linked to the CMS web site. Eventually, state LSE applications and evaluation data could also be posted as models for other states.

It is our hope that HHS adopts the comprehensive model we recommend. We believe that it would lead to improved identification and follow-up care for many children who are exposed to the harmful effects of lead. We are optimistic about this approach for several reasons. First, it encourages states to think critically about how lead exposure affects their Medicaid populations and to devise screening strategies that are more effective than those currently implemented. In particular, we hope that data-based screening recommendations, tailored to meet each state's unique risk patterns, will be well-received by health care providers and result in improved compliance with Medicaid policy. Second, the use of the Peer Review Committee enables CMS and states to tap the experience of individuals in lead poisoning prevention programs throughout the country to inform federal policy decisions. It also provides an important check on the considerable flexibility provided to states under the proposed program. Finally, the proposed evaluation components will help support future federal monitoring and public oversight of the impact of revised lead screening policies on those Medicaid beneficiaries they are designed to benefit. In addition, the inclusion of all

states in the proposed evaluation plan encourages every state to monitor and improve lead screening services. We recognize that there may be elements of our approach that you may wish to modify or perfect. If so, we would welcome the opportunity to work with your staff to achieve the outcomes we all desire.

Complementary Medicaid Lead Screening Policy Recommendations

ACCLPP believes that the proposed LSE process will have a significant positive effect on lead screening services provided to children served by the Medicaid program. However two significant problems remain. Unless addressed, they will continue to undermine the success of efforts to prevent lead poisoning. We urge you to take decisive action in each of the following areas, in order to further the goals of new lead screening policies:

- We recommend that CMS policy be revised to permit federal Medicaid reimbursement for environmental sample analysis as part of the environmental investigation in the home of a lead poisoned child. ACCLPP initially had requested this policy change in a letter dated August 2, 1999 to then-Secretary Shalala. The Committee strongly recommends revision of the State Medicaid Manual to explicitly allow *reimbursement for collection and laboratory analysis of environmental samples for lead content to determine the source or sources of lead exposure for a lead poisoned child.* Without this change, Medicaid reimbursement is limited to a service that does not meet the existing standard of care and that cannot provide information critical to medical decisions about treatment. In order to inform additional discussion of this issue, we request that CMS provide a legal analysis of the restrictions, if any, on Medicaid reimbursement for this type of service, describe precedents in other Medicaid services, and explore alternative approaches for making such a change. Once we have that information, ACCLPP would like to collaborate with you and your staff to find a solution.

- ACCLPP requests your heightened involvement in federal efforts to solve the problem of lead hazard remediation in the homes of lead poisoned children. Most children with lead poisoning are never identified as a result of low screening rates. But for those who ARE identified, there is a widespread failure to control the known lead hazards to which they are exposed. Data from state lead poisoning prevention agencies and from housing agencies consistently show that very few lead hazards in homes occupied by lead-poisoned children are ever remediated, thereby rendering screening programs largely moot. In addition, these known lead hazards remain to poison other children. Understandably, health care providers are dissuaded from complying with Medicaid screening requirements when they perceive that no effective follow-up action will be taken. We urge you to bring this issue to the attention of the President's Task Force on Environmental Health Risks and Safety Risks to Children and to collaborate with other federal agencies, especially the Department of Housing and Urban Development (HUD), the Environmental Protection Agency (EPA), and the Department of Justice (DOJ), to develop a plan to overcome this hurdle, and to take any other steps that you believe will be effective. If we are to achieve the Healthy People 2010 goal of eliminating lead poisoning, controlling known lead hazards in properties that have poisoned a child is a critical step of paramount importance.

Thank you for your consideration of our recommendations. Representatives of ACCLPP would be pleased to meet with you or your staff at your convenience if you would like to discuss our

recommendations or related issues. We look forward to hearing from you about your plans for action on this issue.

Sincerely,

Carla Campbell, MD, MS
Acting Chair
Advisory Committee on Childhood Lead Poisoning Prevention

Attachments

cc: Julie Gerberding, MD, MPH
Richard J. Jackson, MD, MPH
Patrick J. Meehan, MD

Recommendations From

The Advisory Committee On Childhood Lead Poisoning Prevention

On

The Lead Screening Exception For Children Eligible For Medicaid

September 2002

Note to readers: The **following recommendations from ACCLPP are presented in the form of guidance from CMS to states. Thus, everything that appears from this page forward should, unless otherwise noted, be imagined to be part of a package of guidance sent by CMS to state Medicaid agencies, *exactly as it would look*. It is our hope that this format will promote clarity now and may simplify future implementation by CMS.**

Table of Contents

Foreword from the Advisory Committee on Childhood Lead Poisoning Prevention

In 2000, the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP)[1] accepted a request from the Secretary of Health and Human Services for guidance on improving lead screening for young Medicaid beneficiaries who are at risk for lead exposure. An ACCLPP workgroup considered the input of staff of the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) and from state agency representatives and ACCLPP members. The workgroup monitored state screening strategies and developed draft recommendations that were substantially reworked by the full ACCLPP. The new CMS policy presented here is based on ACCLPP recommendations and represents the response of this diverse group of experts to the most recent findings on the nature and extent of childhood lead poisoning in the US today.

ACCLPP believes that states in which childhood lead exposure is relatively rare are justified in seeking ways to limit Medicaid lead screening to sub-populations at risk. States in which lead exposure is common, but only in certain geographic areas or among certain groups, also have a legitimate interest in targeting resources where they will do the most good. At the same time, ACCLPP wants to ensure that, in a world of competing interests and scarce resources, strategies for targeted lead screening are based on sound science and that children who are at risk for lead exposure are screened through positive effort on the part of all sectors of the Medicaid program. The potential for lasting harm caused by early childhood lead exposure remains a serious one among young Medicaid beneficiaries. Lead screening in this group must not be abandoned, nor should it be left to chance.

The new Lead Screening Exception (LSE) process that is described in the following document is intended to accomplish important public health goals while providing maximum flexibility to states. Central principles that have guided the development of this policy are described below.

Guiding Principles of the LSE Process

- The LSE process should lead to effective and sophisticated state policies for identifying through screening those children with elevated blood lead levels (BLLs) who are enrolled in Medicaid. States are encouraged to screen "smarter" rather than "less." The fact that not all Medicaid children need screening in all states should not undermine the screening activities of states with universal screening policies.

- The process should not be so burdensome that states choose to do nothing, potentially assuring continued poor performance. In many states that currently disregard the Medicaid lead screening requirement, it is certain that unidentified childhood lead exposure still occurs. Children in these states will benefit from a well-designed screening program and prompt interventions for identified exposures.

- The process will not alter state responsibility under the Federal EPSDT statutory requirement. Each state retains the obligation to provide required EPSDT lead screening unless it has received an LSE.

- The process must promote the identification of areas and populations of highest risk within each state that chooses to participate. Effective targeting based on reliable data

can illuminate "pockets" of increased risk within a larger population. States with significant variation in the magnitude of local lead exposures should not rely on the use of statewide blood lead prevalence figures to characterize this public health problem.

- Developing an LSE application should prompt a planning process that uses available (or reasonably obtainable) data to illuminate patterns of exposure. The lack of extensive and complete blood lead surveillance data is not an insurmountable obstacle to reasonable targeting. States can benefit from encouragement to think about how the problem of lead poisoning is manifest in their Medicaid populations today and how best to deal with it.

- The process must accommodate variation among states in the magnitude of risk for childhood lead exposure, in program capacities, and in degrees of public and political support for prevention activities. It cannot result in the arbitrary disqualification of states that might benefit. In particular, the process cannot be based on an unattainable "gold standard" for blood lead screening data. The process is built on recognition of the realities of variation in lead risk within states, declining prevalence, low screening rates, and incomplete blood lead surveillance.

- The application process should be based on helpful federal guidance that provides a clear vision of what successful applications would look like.

- The review of LSE applications should be performed by individuals with relevant substantive experience. The outcome should be based on careful review by experts in the theoretical and practical issues involved in targeting screening, rather than on formula or political decision.

- The process must incorporate evaluation procedures that will enable assessment of the impact of the LSE program on service delivery and case identification. A federal evaluation component validates the importance of the activity, while creating a framework for future planning and goal setting.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
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MAY 15 2002

Carla Campbell, MD, MS
Acting Chairperson
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National Center for Environmental Health
1600 Clifton Road, N.E.
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Dear Dr. Campbell:

Thank you for your letter concerning lead screening of young children enrolled in Medicaid. I appreciate hearing the Committee's views on this important subject.

Since you wrote to me, the Director of the Center for Medicaid and State Operations, Dennis Smith, met with you and other members of the workgroup. Mr. Smith clearly stated that no change in policy has been made in the Medicaid program regarding lead screening and that this Department will continue to rely on the expertise of the Centers for Disease Control and Prevention for policy recommendations in this area. The workgroup was assured that Medicaid will not adopt any change in policy on its own.

I look forward to working with you and your colleagues on the Committee in our quest to protect the health of America's children. Please feel free to call me if you have concerns or questions.

Sincerely,

Tommy G. Thompson

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 2 9 2002

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Dear Dr. Campbell:

Thank you for your letter and the recommendations concerning lead screening of young children eligible for Medicaid. As you know, I am committed to ensuring that at-risk children have access to potentially life-saving screening and treatment for lead poisoning.

I share the concerns of the Advisory Committee on Childhood Lead Poisoning Prevention (ACLPP), that the Department of Health and Human Services develop screening policies that are accurate, yet allow states flexibility to respond to local conditions. My staff is in the process now of studying the ACCLPP's recommendation. I will send you our response as soon as they have completed their work.

I look forward to being in touch with you in the near future. In the meantime, please feel free to call me if you have questions or concerns.

Sincerely,

Tommy G. Thompson