ACCLPP

Department of Health and Human Services

Advisory Committee on Childhood Lead Poisoning Prevention

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April 16, 2002

The Honorable Tommy G. Thompson
Secretary
US Department of Health and Human Services
200 Independence Ave, SW
Room 615-F
Washington, DC 20201

Dear Secretary Thompson:

The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) is charged with providing advice and guidance to you and the Department of Health and Human Services regarding new scientific and technological developments and their implications for prevention efforts. The Committee is also charged with reviewing and reporting regularly on childhood lead poisoning prevention practices and recommending improvements in national childhood lead poisoning prevention efforts. Toward this end, we believe that you should be aware of our objection to the proposal being developed by the Centers for Medicare and Medicaid Services (CMS) to delegate to states decisions about lead screening of young children in Medicaid. An alternative course of action is recommended herein for your consideration.

Background

As you know, the US has witnessed great progress in preventing lead poisoning in recent years, as blood lead levels have continued to decline across the general US population, largely due to the continuing public health benefits of earlier regulatory decisions to ban lead in paint, gasoline, food cans, and other consumer products. Yet, some localities continue to face persistently high rates of lead poisoning, as described by the Centers for Disease Control and Prevention (CDC) in an analysis of national survey data from 1999 (Lofgren, Macias, Russakow, et al, *MMWR*, December 2000). Geographic variation is very much a part of the current challenge in designing childhood lead poisoning prevention programs. Significant local risk disparities are highlighted in blood lead screening data collected by seven state and local health departments showing that more than 50% of the children with elevated blood lead levels lived in just 11.3% of ZIP codes (Brown, Shenassa, and Tips, *Small Area Analysis of Risk for Childhood Lead Poisoning*, 2001).

At the same time, data from national surveys and from states and locales have repeatedly shown that childhood lead poisoning is associated with poverty, and Medicaid enrollees account for an estimated 60 percent of all children with blood lead elevations and up to 93 percent of severely lead poisoned children (Kaufmann, et al, *Pediatrics*, December 2000). Since 1989, a screening blood test for lead poisoning has been required by CMS for children receiving care under Medicaid's EPSDT program, but the majority of these children do not receive such testing. A 1998 GAO report estimated that 19 percent of young Medicaid enrollees had been screened. These low rates are confirmed by states' self-reported data; only 8 of 42 states reported a Medicaid lead-screening rate above 20 percent for 1- and 2-year-olds on their Form 416s submitted to CMS for FY 1999.

The ACCLPP recognizes the implications of these developments for lead poisoning prevention efforts in general, and for lead-exposed children in the Medicaid program in particular. We are sympathetic to those states that wish to redirect their EPSDT lead screening resources to other areas due to demonstrably low prevalence rates of lead poisoning. We also applaud those states and localities that have shown initiative in taking charge of this problem through good data collection and analysis, innovative screening and prevention programs, and effective laws and ordinances to advance prevention. However, we note that many more jurisdictions are having difficulty meeting the complex challenge of preventing lead poisoning because of wide variation in lead risks, lack of program resources, and counterproductive state statutes. For these reasons, the ACCLPP accepted Secretary Shalala's request to collaborate with CDC and CMS staff to develop public health-based recommendations on criteria for issuing waivers of mandatory lead screening to individual state Medicaid agencies. We greatly appreciated the HHS commitment to defer issuance of any waivers until these criteria are developed.

Recommendation and Rationale

ACCLPP offers you this update on our progress in developing such criteria and a final schedule for completion of our recommendations so that you may plan accordingly. We also request that you defer further policy decisions on Medicaid lead screening policy until later this year.

Since the Committee accepted the Secretary's request for guidance, ACCLPP has established the Targeted Medicaid Screening Work Group to conduct relevant research, to consider input from CDC and CMS staff, state agency representatives, and ACCLPP members, to monitor progress in state screening strategies, and to develop proposals for consideration by the full Committee. The ACCLPP workgroup has met several times, has scheduled several upcoming meetings, and is working to deliver final recommendations to you this fall. The ACCLPP's fall meeting is scheduled for October 15 and 16, 2002, at which time we will resolve any final issues, if necessary. If we are able to complete work earlier, we will, of course, deliver our final recommendations as expeditiously as possible.

At the ACCLPP meeting held on March 12, 2002, a CMS staff member informed us that the CMS is considering instituting an approach that would marginalize the ongoing ACCLPP process. Specifically, we were told that CMS is currently developing a proposal that would delegate Medicaid lead screening decisions to states, with no approval process or oversight provided at the federal level. CMS staff also reported plans to vet the proposal with CDC, within HHS, and with key Members of Congress before proceeding. This unilateral approach is considerably different from the one we originally agreed upon with the Department.

ACCLPP members are very troubled by this news and strongly urge you to defer consideration of the CMS proposal for revising lead screening requirements for State Medicaid programs until ACCLPP submits its recommendations this fall. We are concerned that a change from federal to state control of the EPSDT lead screening policy will fatally undermine efforts to screen Medicaid children at highest risk in some localities, by falsely creating an impression that lead exposure is no longer a problem for any children enrolled in Medicaid or a priority of CMS. In addition, even though we agree that all states need not universally screen, the evidence suggests that some states will not screen unless they are pushed to do so.

We believe that the Federal requirement for lead screening in the State Medicaid Manual is an important safety provision, ensuring that very disadvantaged children are entitled to adequate lead screening services "appropriate for age and risk factors," as required by the federal Medicaid statute. Thus, we urge you to proceed cautiously in revising this policy. In addition, we understand that in the 1993 settlement agreement for Medicaid class-action lead screening litigation (Thompson v. Raiford) HHS stipulated that CDC is an "appropriate body" to provide guidance on lead poisoning prevention policy. In recent years, CMS has consistently deferred to CDC in interpreting the "age and risk factors" portion of the federal statute and we urge you to continue this productive relationship.

ACCLPP is also concerned that, with notable exceptions, most States have a poor track record in providing lead screening to children enrolled in Medicaid and in demonstrating their ability to document, track, and analyze such screening. Given this reality, we fear that poor children may be further disadvantaged by devolution of decision-making on this issue to states that have not provided lead screening up to now, or that cannot generate reliable data upon which to base decisions on targeting screening.

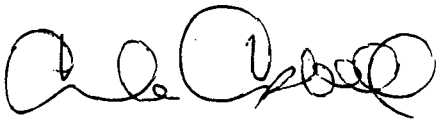
ACCLPP appreciates the importance of providing states with flexibility in administering Medicaid, yet we remain concerned about the need to provide adequate protections for young children at high risk for lead poisoning. As new evidence about lead poisoning patterns nationwide has emerged over the past 18 months, we are reconsidering our own thinking about a number of issues, including new approaches to ensure a reasonable balance between flexibility and accountability for states in designing and delivering lead screening services to Medicaid-enrolled children.

Though the absolute number of poisoned children in the US is lower than ever before, we believe that it is crucial to finish eliminating lead poisoning in order to ensure that every young child has an opportunity to develop to his or her fullest potential. Doing so requires routine blood lead screening of high-risk subgroups to identify and treat children with elevated blood lead levels before they develop significant cases of lead poisoning. As with other diseases that were formerly epidemic, identifying and treating the cases in the tail end of the epidemic is the most difficult challenge.

Thank you for your consideration. We would be pleased to meet with you or your staff to discuss these issues at your convenience, now or after we have submitted our recommendations, if that would be useful. Please let me know if we can provide any further information or be of any additional assistance.

We look forward to continuing to collaborate with you and your staff on improving childhood lead poisoning prevention efforts nationwide.

Sincerely,



Carla Campbell, MD, MS
Acting Chairperson
ACCLPP

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

MAY 15 2002

Carla Campbell, MD, MS
Acting Chairperson
Advisory Committee on Childhood Lead
Poisoning Prevention
National Center for Environmental Health
1600 Clifton Road, N.E.
Atlanta, GA 30333

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

Tommy G. Thompson

ACCLPP

Department of Health and Human Services

Advisory Committee on Childhood Lead Poisoning Prevention

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August 23, 2002

The Honorable Tommy G. Thompson
Secretary, U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 615-F
Washington, DC 20201

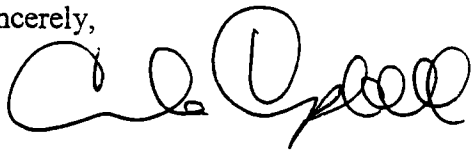
Dear Secretary Thompson:

The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) requests your assistance to ensure continued research to identify effective methods for reducing children's exposure to lead and other environmental hazards. A recent Maryland Court of Appeals ruling involving such research conducted by the Kennedy Krieger Institute implied that such research is inherently unethical. While not commenting on the merits of the particular suit covered by this ruling, the ACCLPP believes that highly ethical research to objectively test the safety and effectiveness of lead poisoning prevention methods can and has been conducted. Furthermore, we believe that continuing such research is *essential* if progress towards eliminating childhood lead poisoning is to continue. The Department of Housing and Urban Development's national survey of the housing stock estimates that 25 million homes and apartments pose "significant lead hazards," of which more than 5 million are currently occupied by a child under age 6. Clearly, it is not feasible to quickly rebuild most or all of these units or to safely remove all of their leaded paint.

What is needed is a continued expansion of programs and resources to prevent exposure of children to lead from paint and continued improvement in our knowledge of how to do this in the safest and most cost-effective way. Controlled studies, performed in an ethical manner, are the best way to expand this knowledge. It is therefore vital that HHS continue and expand funding for such research. In addition, we urge HHS to produce a set of clear guidelines for the design and review of research protocols involving interventions to prevent lead poisoning and similar environmental health conditions. Currently, the National Academy of Sciences (NAS), with anticipated support from the Department of Housing and Urban Development, is planning to convene an expert panel to examine ethical issues that may arise in conducting research to eliminate housing-related conditions associated with childhood lead poisoning and other diseases or injuries. We strongly encourage HHS, through its Office of Human Research Protections, to be actively engaged in the NAS study so it can assist HHS in formulating its own guidelines.

Without a set of clear ethical guidelines for environmental health prevention research, we are concerned that public confidence in and support for such research will be eroded. This would have a profoundly negative impact on the future health of children who are most vulnerable to exposure to lead and other environmental hazards. We appreciate your attention to this matter and would be happy to discuss it further with you or your staff.

Sincerely,



Carla Campbell, MD, MS
Acting Chairperson, ACCLPP

cc: Dr. Julie Gerberding, Director, Centers for Disease Control and Prevention
Dr. Richard Jackson, Director, National Center for Environmental Health

ACCLPP

Department of Health and Human Services

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Jerry Zelinger, M.D.

September 23, 2002
The Honorable Tommy G. Thompson
Secretary
U. S. Department of Health and Human Services
200 Independence Ave., SW
Room 615-F
Washington, DC 20201

Dear Secretary Thompson:

The Advisory Committee for Childhood Lead Poisoning Prevention (ACCLPP) wishes to bring to your attention the potential public health problem of lead poisoning among adopted and refugee children. Each year over 100,000 children are adopted in the United States, with almost 17,000 from overseas. Throughout the 1990s this number has been consistently increasing. The most common countries from which children are adopted are Russia, China, South Korea, Guatemala, and Romania. Many of these countries have documented problems with lead exposure and toxicity. Almost 90% of these adopted children are under five years of age, a population especially vulnerable to the effects of lead.

Recent studies have found that a significant proportion of immigrant and adopted children have elevated blood lead levels, depending on the country of origin (1,2). According to one study, 40% of children from Cuba and Haiti, 37% from Asia, 27% of Vietnam and Africa and 25% from the Near East had elevated blood lead levels. Overall, approximately 11.3% of adopted foreign-born children have elevated blood lead levels (1).

Prior to arrival into the United States, all immigrants and refugees are required to have a medical examination overseas by a physician approved by the U.S. embassy or consulate to perform medical examinations for immigrant visas in that country. This examination focuses primarily on detecting serious contagious diseases and disabilities. For children 15 years of age or older, a chest radiograph examination for tuberculosis and blood tests for syphilis and HIV are required. Children younger than 15 years of age are tested only if there is reason to suspect any of these diseases. Finally, there is a requirement to show proof that a child has received the recommended vaccines established by the Advisory Committee on Immunization Practices, unless the prospective parents sign a waiver indicating their intention to comply with the immunization requirements within 30 days after the child's arrival into the United States. Blood lead testing is not required.

Upon entry into the United States, the American Academy of Pediatrics recommends that clinicians conduct blood lead screening tests for children who have been adopted or have emigrated from countries where lead poisoning is prevalent (3). But this is only a recommendation (not a requirement), and anecdotal evidence suggests that blood lead screening among this population is not yet routine. And, since many children with blood lead elevations have no obvious clinical manifestations, their lead exposure may go undiagnosed, even as they develop health problems such as anemia, impaired growth and development, lower I.Q. levels, and attention and behavioral problems. Some effects, such as neurodevelopmental effects, may remain with a child throughout his/her lifetime.

Under current regulations and routine practice, foreign-born children with elevated blood lead levels may never be identified. As a result, their parents would lack information that could help them maximally improve their children's growth, development, and prospects for the future. Furthermore, children with blood lead elevations would never receive appropriate medical treatment to reduce their blood lead levels and educational and environmental interventions to protect them from additional lead exposure. Lastly, identification of children with elevated blood lead levels might lead to further investigation and remediation of lead exposures in these children's home countries, preventing other children from becoming poisoned. We hope that you will work with us to solve this problem by providing information and guidance to targeted parents and physicians and other health care providers.

We, the Advisory Committee, urge you to address the public health importance of childhood lead poisoning in this growing population. We request your assistance in providing information on this subject to your counterpart at the U.S. Department of State, and to appropriate agencies within HHS. To facilitate this process, ACCLPP in conjunction with staff from the Centers for Disease Control and Prevention, has written two simple letters (which are attached) to parents of adopted and immigrant children, respectively, explaining the possibility for prior lead exposure of these children and recommending lead screening as part of the medical evaluation provided during the adoption or immigration intake process. We think that these letters could be disseminated to adopting and immigrant parents through the State Department in the course of their work with such parents. They might also be utilized by the U.S. Immigration and Naturalization Service (INS). In addition, we think that several HHS agencies can play important roles in disseminating information about this problem.

Specifically, HHS programs that educate physicians and other health care providers, provide health care to immigrant or refugee populations, or provide support services for such populations could all make a difference in changing practice. We request your help in making these materials available to the Secretary of State and his staff, to INS staff, and for use within HHS.

Thank you in advance for your consideration of our request. Committee members would be pleased to meet with you or your staff should you have any further questions or concerns about our request. We look forward to working with you on this project in the future.

Sincerely yours,

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

References

1. Paul L. Geltman, Mary Jean Brown, and Jennifer Cochran Lead Poisoning Among Refugee Children Resettled in Massachusetts, 1995 to 1999 Pediatrics 2001 108: 158-162.
2. Elevated blood lead levels among internationally adopted children--United States, 1998. MMWR Morb Mortal Wkly Rep. 2000 Feb 11;49(5):97-100.
3. Committee on Environmental Health. Screening for Elevated Blood Lead Levels Pediatrics 1998 101: 1072-1078.

Dear Parent of an Adopted Child from Overseas:

As you go through the joy of adopting a child and the anticipation of providing him or her with a future full of promise, we would like to talk with you about a health matter for which you may not have received information.

Blood lead levels in foreign-born adopted children may be a health concern.

- Lead is a metal used worldwide. The most common source of lead exposure for children in the U.S. is from lead-containing paint in a home built before 1978. Lead exposure in other countries varies from that in the U.S. due to different policies, practices and regulations. Major lead exposure sources include lead from gasoline, ceramics, and industrial uses. Many countries still use leaded gasoline, although the U.S. has banned this years ago.
- Some adopted children may have been exposed to lead. Studies have shown that adopted children tend to have higher lead levels in their blood than do U.S.-born children.
- Studies have linked some learning, attention, behavioral and developmental problems to elevated lead levels.
- Early identification of elevated blood lead levels can benefit a child's health by triggering appropriate medical management and other follow-up care.
- Public health departments can offer guidance, which may include environmental inspection, by ensuring a safe environment to prevent further lead exposure.
- For more information on lead, contact any of the following:
    - Your child's health care provider or doctor
    - Your local health department
    - The Childhood Lead Poisoning Prevention Branch at the Centers for Disease Control and Prevention (404-498-1420 or www.cdc.gov/nceh/lead)
    - The National Lead Information Center (800-424-LEAD)
    - The Alliance to End Childhood Lead Poisoning (202-543-1147 or www.aeclp.org)

Have your child's blood lead level checked.

- A simple blood test can detect an elevated lead level.
- When you return home with your child, ask your child's health care provider or doctor to test your child for lead.
- If a level of concern is found, your child's doctor can follow your child to manage or prevent health problems.
- If your child's level is acceptably low, your child's doctor can follow local and state recommendations for any further lead testing.

We wish you every joy as a parent of your newly adopted child!

The Advisory Committee for Childhood Lead Poisoning,
U.S. Department of Health and Human Services

Dear Parent of an Immigrant Child from Overseas:

Blood lead levels in immigrant children may be a health concern.

- Some immigrant children may have been exposed to lead. Studies have shown that these children tend to have more lead in their blood than do U.S.-born children.
- Studies have linked some problems with the way children learn, pay attention, act and develop to blood lead levels that are higher than normal.
- Finding children with high lead levels early can help the child's health by leading to follow-up sooner with a doctor.
- Public health departments can offer help to protect children from getting more lead in their bodies when children have elevated (too high) blood lead levels. This may include inspections of the home
- For more information on lead, contact any of the following:
    - Your child's health care provider or doctor
    - Your local health department
    - The Childhood Lead Poisoning Prevention Branch at the Centers for Disease Control and Prevention (404-498-1420 or www.cdc.gov/nceh/lead)
    - The National Lead Information Center (800-424-LEAD)
    - The Alliance to End Childhood Lead Poisoning (202-543-1147 or www.aeclp.org)

Have your child's blood lead level checked.

- A simple blood test can detect an elevated lead level.
- Ask your child's health care provider or doctor to test your child for lead.
- If the lead level is high, your child's doctor can follow your child to watch for and take care of any health problems.
- If your child's level is low, your child's doctor can follow local and state rules for any more lead testing.

We wish you good luck in your new home in the United States!

The Advisory Committee for Childhood Lead Poisoning,
U.S. Department of Health and Human Services

ACCLPP

Department of Health and Human Services

Advisory Committee on Childhood Lead Poisoning Prevention

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Jerry Zelinger, M.D.

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:

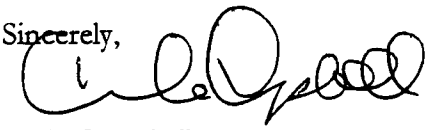
- We recommend that CMS policy be revised to permit federal Medicaid reimbursement for environmental sample analysis as part of the environmental investigation in the home of a lead poisoned child. ACCLPP initially had requested this policy change in a letter dated August 2, 1999 to then-Secretary Shalala. 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

Children's
Environmental
Health Network

Statement from the
Children's Environmental Health Network
before the
CDC Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP)
San Francisco, CA
October 15, 2002.

The Children's Environmental Health Network is a national multi-disciplinary non-profit organization whose mission is to protect the fetus and the child from environmental hazards and to promote a healthy environment. Our organization is internationally recognized for developing relevant and credible resources on children's environmental health, and for bringing together varied organizations with a broad range of viewpoints to ensure child health protection. CEHN has a long history as a policy leader, and as a bridge between the public health and scientific communities and community health and environmental advocacy organizations.

We are here this morning to voice our sincere disappointment and concern that the Secretary, for the first time, has overruled to recommendations of the CDC staff of nominees to this committee. The integrity stature and expertise offered to this committee by Dr.. Michael Weitzman, Pediatrician in Chief at Rochester General Hospital; Dr. Bruce Lanphear, Sloan Professor of Children's Environmental Health at the University of Cincinnati; and Dr. Susan Klitzman, Associate Professor of Urban Public Health at Hunter College. Moreover, their absence on the panel deprives the public of critical insights and experience to guide the CDC in its work on lead prevention issues. We recommend that these experts be reinstated so that their valuable work for the CDC can continue.

In addition we are alarmed that new appointees to the committee include several people who have worked directly for the lead industry, and who have taken positions on lead levels which are known to a risk to children's health. Because this committee has been instrumental in setting federal lead poisoning screening and prevention policies, we strongly protest this unprecedented effort to transform turn this previously unbiased the scientific advisory board by appointing members who have financial ties to the lead industry. The importance of independent scientific advisors when the public health is at stake cannot be compromised. Therefore the appearance of conflict of interest alone should disqualify those new appointments make by the Secretary.

The second issues we would like to address to the Committee the ongoing implementation of the CDC's Lead Prevention Program and long range Strategy. Currently the CDC's program includes three key programmatic elements - Primary Prevention, Effective Screening and Surveillance, and Public and Professional Education and Communication. Each of these has proven essential in an effective strategy to reduce childhood lead poisoning. The timing for the funding and implementation of this strategy is critical and imminent. We hope the members of this committee will strengthen and accelerate the implementation of this comprehensive approach.

Respectfully submitted by
Renee L. Robin, California Director,
Children's Environmental Health Network

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April 24, 1996

Committee on Childhood Lead Poisoning
c/o Henry Falk, M.D.
Environmental Hazard & Health Effects
Mail Stop F28
Center for Disease Control
4770 Buford Highway NE
Atlantic, Georgia 30341-3724

Dear Dr. Falk:

I am sending you the original and ten copies of this letter to the Center for Disease Control Committee on Childhood Lead Poisoning and request that you do me the favor of distributing copies to the members of the committee when they arrive for its meeting on April 29 and 30. I understand the meeting is to reconsider the CDC guidelines under which childhood blood leads above 10 µg/dL are labeled as "lead poisoning."

In his letter to you of September 7, 1995, Dr. Sergio Piomelli expressed the opinion that, although lead probably has adverse effects on children at levels around 10 µg/dL, those effects are not significant enough to warrant the label "poisoning." I have no expertise in determining the level at which lead's health effects become significant, but my long experience as an activist trying to protect children from lead puts me in as good a position as anyone to assess the real world impact of medical pronouncements about the health effects of lead. Based upon that experience, I believe that the oath to "do no harm" requires physicians to consider the significance of the health effects of lead at relatively low blood lead concentrations in reevaluating the guidelines.

I start by explaining my involvement in the lead issue. I go into some detail because the story not only establishes my credentials, but also helps to frame the issue now before the committee. Beginning in the 1960's, I represented tenants in poor neighborhoods of Brooklyn whose children were exposed to lead paint dust and flakes. When I became a staff attorney with the Natural Resource Defense Council in 1972, the first matter that I took on was lead in gasoline. I wanted not only to reduce lead in gasoline, but also to make lead an issue for the middle class as well as the poor in order to secure broader political support for protecting poor children from lead paint. In 1972, I filed a lawsuit against the Environmental Protection Agency. The Court of Appeals for the District of Columbia Circuit issued an order that resulted in the promulgation of the regulations to reduce the lead content of gasoline. In 1973, I filed a lawsuit to require EPA to issue a national ambient air quality standard for lead. A federal district court, affirmed by the Court of Appeals for the Second Circuit, ordered EPA to issue such standards, but EPA eventually tried to make the standards meaningless by floating a proposal to set it at 5 µg of lead per cubic meter of air. At this point, I enlisted the help of Drs. Herbert Needleman and Sergio Piomelli to expose the errors in the agency's reasoning. Through our efforts and those of many others , the agency promulgated a standard of 1.5 µg per cubic meter.

The reasoning behind that standard throws the CDC's present deliberations into bold relief. The agency began by identifying childhood blood leads above 30 µg/dL as unacceptable. Deciding to

ensure that 99.5 % of all children have blood leads below that level, the agency calculated that it needed to reduce average lead levels in children to 15 µg/dL. Because the agency believed at that time that children picked up enough lead from nonair sources such as food, water, and paint to bring the average level up to 12 µg/dL, it reasoned that the contribution from air borne lead should account for no more than 3 µg/DL. Because the agency believed that there was a 2:1 ratio between blood lead levels and air lead concentrations, it set the standard at 1.5 µg per cubic meter of air.

It seemed to me at the time that the EPA radically underestimated the blood lead/air lead ratio and, accordingly, the contribution of lead in gasoline to blood leads. I thought that EPA had failed to take account of the long term effect of lead in gasoline on lead concentrations in food, water, and background dust.[1] But, I could get no scientist to back up my lay intuition. It now seems that I may well have been correct, given that average blood leads levels fell far below 12 µg/dL after lead was taken out of gasoline.

The lead industry asked the Court of Appeals for the District of Columbia Circuit to reverse the EPA standard. The three judges hearing the case did not seemed much impressed with the Environmental Protection Agency's explanation of why 30 µg/DL was a level of concern and with the oral argument of the Department of Justice lawyer on that score. In my oral argument, I pointed to the studies suggesting that blood leads below 30 µg/DL seem to be related to some reduction in intelligence. At that point, one of the judges asked me how his growing up next to a large lead smelter had affected his intelligence. I fell back upon the CDC's conclusion that blood leads of 30 µg/dL was a level of concern. Another judge then asked, "Isn't the CDC the organization that brought out the swine flu vaccine?" The question was meant in large part, but not entirely, as a joke. In unanimously affirming the EPA standard, the judges relied heavily upon the CDC because of its reputation for expertise and sound judgment.

That reputation for sound judgment, which was so essential in preventing what would have been a disastrous judicial reversal of the effort to get official recognition of the dire health effects of lead, is jeopardized if Dr. Piomelli is correct that the existing guidelines fail to distinguish between the significant and insignificant health effects. People look to physicians in general and the CDC in particular for judgments about the significance of threats to health. For example, judgments about significance are built into CDC circulars on precautions that travelers should take and physicians' decisions whether to prescribe medication for "borderline" hypertension, hyper cholesterol, etc.

A failure to make a judgment about significance cannot be defended upon the basis that the existing guidelines only flag health effects and leave other units of government to make judgments about their significance and how to respond to them. Such a defense would be disingenuous because the current guidelines label childhood lead levels above 10 µg/dL as "poisoning." As a practical matter, such a label makes it difficult for other units of government to do anything but respond to such blood leads as an emergency. This is so because of the political incentives created by such a label for elected and appointed officials and because of the fear instilled in parents. I was recently asked by a major university press to review a manuscript of a book aimed at parents whose children have elevated blood leads. It struck me that the manuscript used language about the health effects of blood leads in the low teens that would create alarm in parents out of proportion to the health effects at these levels actually identified in the

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[1]Schoenbrod, Preface to Herbert L. Needleman & Sergio Piomelli, The Effects of Low Level Lead Exposure (Natural Resources Defense Council & American Lung Assoc. 1978).

studies discussed by the authors. When I raised this issue, the authors answered that the CDC had called such blood leads "poisoning." The CDC characterization ended that discussion.

Some activists want to apply the label "poisoning" to blood leads without significant health consequences because they wish to use the lead issue to secure better housing for poor people, to get money judgments for them from landowners, and in general to render a verdict of guilt against society. There are three problems with the CDC becoming a party to this strategy. First and foremost, it requires the CDC to make judgments about social and economic policy, rather than medical effects. The CDC has no such mandate. Exceeding its mandate in this way would squander its good reputation, which it needs to fulfill its mandate.

Second, failing to distinguish between significant and insignificant health effects takes attention away from the children who most need help.

Third, there is a considerable economic and legal literature to suggest that the burden of such a strategy will in the end fall more heavily on its intended beneficiaries than on wealthy landowners. Labeling housing unfit for human habitation unless the lead is abated means that the housing must be abandoned or repaired at considerable expense. Not infrequently, the housing is owned by the children's parents. Even when the parents are tenants, they will often have to move or pay higher rents. Even if the parents are protected by a lease, the reduction in supply of affordable housing and the repair costs means that the average poor family will have to devote more of their limited means to rent or crowd into a less commodious apartment. Even if the area has rent control, poor tenants will suffer from the decrease in the supply of controlled housing. These physical and economic dislocations can have physical and psychological health effects of their own. Such consequences are worthwhile to save a child from real lead poisoning, but not from insignificant health effects. In sum, please consider that CDC guidelines used to make housing policy are a drug with adverse side effects.

It took so long to get official recognition of the severe adverse effects of lead because those who opposed the removal of lead from gasoline (additive makers, petroleum companies) were more cohesively organized than who would benefit (parents and children). I have showed at length how these cohesively organized interests worked to slow official recognition of the scientific findings suggesting that lead has significant adverse effects at what were previously thought to be low levels.[2] Now, however, with lead out of gasoline, those who have a stake in exaggerating the health effects of lead (tort attorneys, lead removal contractors, government agencies and researchers whose funding is increased by public alarm about lead, and activists in search of a crusade) are more cohesively organized than the general populace, which has an interest in an approach sensitive to the significance of threats present.

Sincerely,

David Schoenbrod

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[2]Schoenbrod, "Why the Regulation of Lead Has Failed," in Low Level Lead Exposure: Clinical Implications of Current Research (H. Needleman, ed., Raven Press, 1980). The title of this chapter was a hyperbolic way of suggesting that the lead additive manufacturers were able to prevent government from substantially reducing the lead content of gasoline for decade after there was sufficient evidence to know that such reduction was prudent.