



Providing Primary Care for
Children and Teens

The Children's Hospital of Philadelphia Primary Care Center

St. Leonard's Court, Suite 110
39th and Chestnut Streets
Philadelphia, PA 19104-4399

215-590-5090

October 7, 2005

The Honorable Michael Leavitt
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 Leavitt:

The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) wishes to open a dialogue with you and your department regarding lead screening of children who are eligible for Medicaid. Specifically, we are following-up on recommendations we have previously submitted to HHS on revisions to the Medicaid lead screening policy, as well as offering three further suggestions for your consideration. As federal and state governments struggle to contain Medicaid budgets, it is vital that resources be directed where they can be expected to yield the greatest results with minimal waste. We believe that our recommendations as detailed below may help accomplish this.

Background

As you know, current CMS policy requires state Medicaid programs to provide blood lead screening tests to all young children as part of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) program. 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. Due to concern about the need to increase lead screening of children receiving Medicaid, the ACCLPP published in December 2000 in the Morbidity and Mortality Weekly Report, "Recommendations for Blood Lead Screening of Young Children: Targeting a Group at High Risk." This publication recommended that state health departments and Medicaid agencies share data on lead screening of children, to ascertain the number and proportion of children receiving screening. It gave further recommendations to both state agencies and health care providers on how to increase screening of children covered by Medicaid. ACCLPP

The Children's Hospital of Philadelphia 

The Children's Hospital of Philadelphia is an equal opportunity employer and patients are accepted without regard to race, creed, color, handicap, national origin or sex.

continues to be very concerned about the substantial number of Medicaid children who are not screened.

Recently, regional and local variations in lead exposure have led a few, largely lower-risk, states to conclude that their Medicaid resources might be better directed by limiting their blood lead screening to a subset of Medicaid enrollees where the risk for lead exposure has been demonstrated. Consequently, by 1999, two states requested waivers from CMS (then HCFA) of the mandatory lead screening requirement.

In response to these inquiries, former HHS Secretary Donna Shalala requested that ACCLPP develop recommendations on how the federal Medicaid program might allow states to adopt targeting strategies for lead screening. ACCLPP agreed to consider the issue, established a workgroup, and ultimately submitted a set of recommendations to HHS Secretary Tommy Thompson in September 2002, titled "Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention on the Lead Screening Exception for Children Eligible for Medicaid."

In November 2002, we received a response informing the committee that HHS staff were in the process of studying the ACCLPP recommendations. It is our understanding that CDC and CMS have engaged in staff-level discussions about this issue in the interim, but, as no formal report or response has ever been provided to ACLPPP, specific progress toward this work is unknown at this time. Most recently, CMS staff were invited to our October 2004 and March 2005 ACCLPP meetings to present a status report, but did not attend.

Summary of ACCLPP Lead Screening Exception (LSE) Proposal

In our recommendations, ACCLPP suggested that HHS invite states to apply for a Lead Screening Exception (LSE), which would be established as a new option under EPSDT. 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 lead screening surveillance data. ACCLPP's intention is to encourage effective and sophisticated state policies for screening "smarter" rather than "less." ACCLPP acknowledges that if targeted lead screening is done properly, it may result in screening of more children in a more effective manner; *that is, more children at increased risk would be screened while fewer children at lower risk would be screened.* ACCLPP also made it a priority to 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.

ACCLPP recommendations included specific guidance on format and content of state applications, an evaluation plan, and model applications from fictitious states. A list of lead screening resources was also provided. ACCLPP recommended that only states with

an approved lead screening exception be permitted to conduct targeted screening. The default policy would be for universal blood lead screening of every Medicaid child at ages 12 and 24 months, which is the current Medicaid mandate for lead screening of these children.

A new Peer Review Committee, appointed by CDC, would review state applications. ACCLPP has recommended that all states be eligible to apply for an LSE; no eligibility limits based on blood lead prevalence are proposed. ACCLPP left the door open to a wide array of targeting strategies. The key hurdle for an applicant state would be presentation of a persuasive, evidence-based case to their expert peers.

Recommendations

In an effort to reinvigorate federal efforts to improve Medicaid services for lead-poisoned children, ACCLPP offers the following four recommendations for your consideration:

1) **Direct CMS staff to develop (with CDC) and publish within 90 days a proposed revision to the State Medicaid Manual pursuant to ACCLPP's September 2002 LSE recommendations.** CMS has failed to act on our recommendations after more than two years and has not accepted our prior offers of assistance and collaboration in developing implementation strategies. We believe that action is still appropriate, necessary, and timely – and we would appreciate due consideration of the recommendations that were developed upon request. At this juncture, we suggest that a Secretarial directive is required to jumpstart the process at CMS. Further, we recommend that CMS's proposed policy be published in the *Federal Register* for a 60-day public comment period prior to implementation. As stated in our prior correspondence, ACCLPP members stand willing to assist and collaborate with HHS staff working on this issue.

2) **Consider supporting a demonstration of the proposed LSE process to evaluate its effectiveness before adopting it program-wide.** One approach to moving forward with LSEs could be for HHS to support a demonstration project in a sample of states with CDC and CMS jointly participating in this endeavor. The initiative could be designed to document the process of implementing the policy in actual program settings, evaluate its effectiveness in better targeting Medicaid resources, and serve as a basis for broader application in the future.

3) **Take advantage of CDC expertise, experience, and resources in collaborations with CMS in supporting and overseeing Medicaid policy and practice for lead screening.** ACCLPP urges you to look for ways to encourage CMS to utilize the extensive expertise of the CDC's Lead Poisoning Prevention Branch (LPPB) in its efforts to improve Medicaid screening and treatment policies. CDC's role in funding, evaluating, and collaborating with its grantees in state and city health department lead poisoning prevention programs provides CDC staff with firsthand knowledge of the challenges and opportunities associated with lead screening and treatment. As CDC's grant program has increasingly focused on high-risk subgroups, there is an increasing emphasis on Medicaid populations throughout CDC's own efforts, so it is a natural - and

likely fruitful - area of collaboration. In fact, CDC already requires its grantees to develop capacity to link Medicaid enrollment and blood lead surveillance databases in order to track screening provided to Medicaid children. The reality is that CMS staff in Baltimore may not have had the opportunity to develop such specialized expertise – but existing expertise can be readily tapped to develop more effective and focused use of Medicaid resources. It is vital that resources be directed where they can be expected to yield the greatest results with minimal waste.

4) Collaborate with the US Department of Agriculture's Women, Infants and Children (WIC) Program (for supplemental nutrition) to reduce barriers to lead screening. Because many Medicaid enrollees are also served by state WIC programs, it is natural to explore ways for the two programs to collaborate in reaching high-risk families with appropriate screening services and health information. Yet, this potential remains largely untapped. CDC is encouraging its grantees to explore partnerships with WIC programs for lead screening outreach and evaluation. However, various policy and program issues are arising around the country. Blood lead testing done in WIC clinics for Medicaid-enrolled children sometimes presents Medicaid reimbursement issues that were not anticipated in the development of current policies, suggesting that a review may be timely. Thus, we ask that you invite representatives of the WIC program to collaborate with CDC and CMS in reviewing federal policy and programs in this area to identify and address barriers to effective collaboration and lead screening.

In closing, ACCLPP urges you to direct your attention to the issue of lead screening for Medicaid-eligible children. We believe that there are a number of specific steps that you can take right now to improve the services provided to Medicaid children while also being a responsible steward of state and federal Medicaid resources. We thank you in advance for your consideration of these issues, and we look forward to hearing from you in the near future. We would be pleased to meet with you or your staff to discuss any of these issues in greater detail.

Sincerely yours,



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