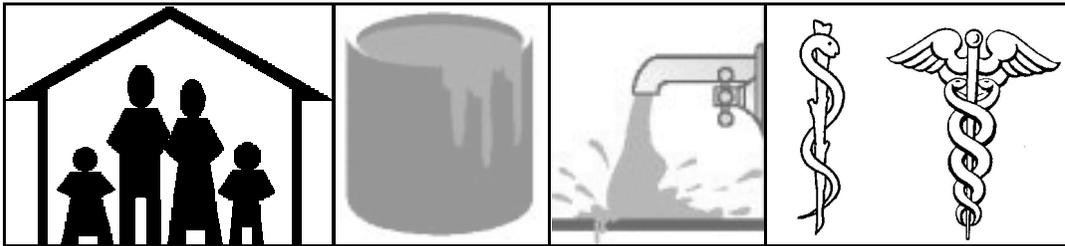


State of New York
Office of the Attorney General
Health Care Bureau

An Ounce of Prevention: Best Practices for Increasing Childhood Lead Screening by New York's Managed Care Plans



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Health Care Bureau

The Health Care Bureau (HCB) is part of the Division of Public Advocacy in the Office of the New York State Attorney General. The HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide, through:

- **Operation of the Health Care Helpline.** This toll-free telephone hotline provides assistance to New York health care consumers by employing staff who provide helpful information and referrals, investigate individual complaints, and attempt to reach a resolution that will help to ensure that each consumer obtains access to the health care to which the consumer is entitled.
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- **Consumer Education.** Through education initiatives, the HCB seeks to acquaint New Yorkers with their rights under the Managed Care Consumer Bill of Rights and other health and consumer protection laws.
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SUMMARY

In an ongoing effort to protect children from lead poisoning, the Attorney General has compiled the Best Practices contained in this report to help HMOs and other health plans comply with New York's childhood lead screening law. The Best Practices were collected as a result of an inquiry by the Attorney General's Health Care Bureau into the policies and practices used by HMOs in New York to comply with the state's lead screening mandate. This inquiry followed a report released by the Health Care Bureau last year showing that many Medicaid and Child Health Plus health plans throughout the state failed to screen an adequate number of children for lead poisoning, while other health plans screened children at a relatively high rate.

The Best Practices compiled by the Attorney General are based on the more effective lead screening strategies gleaned from the inquiry, as well as successful lead screening initiatives in other states. If all HMOs and health plans were to implement these Best Practices, it would go a long way toward achieving the law's goal of universal childhood lead screening so as to eradicate childhood lead poisoning in New York once and for all.

INTRODUCTION

In July 2004, the Attorney General released “Getting the Lead Out: Are New York’s Managed Care Plans Complying with the State’s Childhood Lead Screening Law?,”¹ a report that tracked compliance among Medicaid and Child Health Plus health plans with the state’s lead screening mandate. Under the mandate, HMOs and health care providers are required to test all children for lead poisoning at both the age of 1 and the age of 2.² Early lead testing, detection and treatment are essential to achieve the state and federal goal of eradicating childhood lead poisoning by 2010.³

As part of the report, the Attorney General produced a Childhood Lead Screening Compliance Profile using plan performance data released annually by the New York State Department of Health (State DOH).⁴ The Compliance Profile demonstrated that many Medicaid and Child Health Plus health plans have failed to screen children for lead poisoning at an adequate rate, thus placing New York’s children at unnecessary risk of health impairments. At the other end of the spectrum, several plans consistently achieved high rates of childhood lead screening.

The Attorney General’s report also revealed a disconcerting overall trend: average statewide lead screening rates have actually declined slightly among Medicaid plans in recent years and have remained stagnant for Child Health Plus plans.⁵ This trend takes on greater significance because Medicaid and Child Health Plus plans cover the children at greatest risk of exposure to lead.⁶

Simultaneously with the release of the report, the Attorney General’s Health Care Bureau commenced an inquiry to determine how HMOs and other health plans are ensuring that all 1- and 2-year-old enrollees are screened for lead poisoning, in compliance with the state’s lead

screening mandate.⁷ Letters were sent to the low-performing and high-performing plans requesting detailed information on each plan's efforts to comply with the law. The Health Care Bureau subsequently reviewed the lead screening compliance materials and policies that the health plans provided and discussed lead screening initiatives with various stakeholders, including health plan staff, providers, advocacy groups, childhood lead poisoning coalitions and government lead poisoning professionals.⁸

Based on the information, ideas and concerns that the inquiry generated, as well as the experiences of other states, the Attorney General has developed the Best Practices and policy recommendations contained in this report that will help managed care plans increase their lead screening rates and fully comply with the law in the future. Clearly, the entire burden for universal lead screening does not fall upon the health plans alone. These Best Practices target only the health plan component of the state's multi-faceted childhood lead screening agenda. Parents, providers and public health advocates must also play an active role in ensuring that every child gets screened at the required ages.

Adherence to the Best Practices should not be construed or interpreted as a measure of compliance with the law, but rather as a means toward increased lead screening. Ultimately, compliance comes down to the number of children screened annually by each plan. For this reason, the Attorney General will continue to monitor the health plans' annual lead screening rates and compliance practices to help ensure that all efforts are made to achieve universal screening of all 1- and 2-year-olds, particularly among those plans that consistently exhibited low screening rates in the past.

Finally, the Best Practices Guidelines listed below are not exhaustive. Therefore, the Attorney General encourages health plans and providers to evaluate their own internal practices to continually develop new lead screening strategies in response to their particular circumstances and experiences.

BEST PRACTICES

1. Plans Should Increase Efforts to Screen 1-Year-Olds

Even though the law mandates screening at age 1 and 2, the Attorney General's inquiry found that many health plans are overlooking 1-year-olds in their lead screening compliance policies and materials, focusing almost exclusively on 2-year-olds. For example, some plans established lead screening tracking databases that only track testing of 2-year-olds.⁹ Other plans use written materials that suggest or explicitly state that compliance with the lead screening mandate is determined by the number of 2-year-olds screened, without regard for 1-year-olds.¹⁰ Certain plans offer incentives and recognition awards to providers for high lead screening rates – a commendable practice cited in this report – yet the reward is based solely on the number of 2-year-olds screened.¹¹ Finally, some plans send lead screening reminders to parents when their children turn 2, but not when they turn 1.¹² In contrast, other plans, such as Excellus, HIP and HealthNow, send birthday card reminders to parents just before the child's first and second birthdays to ensure that screening occurs at both ages.

Ignoring 1-year-old screening is not only illegal, but it can also have profound public health consequences. Because children become more mobile, exploring the world tactually and orally, at around the age of 1, they also become more likely to encounter lead-contaminated areas of the home, such as door frames and window sills, and to ingest lead chips and inhale lead dust.¹³

Consequently, the blood lead levels of children exposed to lead tend to rise rapidly between 6 and 12 months, and to peak between 18 and 24 months.¹⁴ Recent research has found that even small levels of lead poisoning over a relatively short period of time can cause a permanent reduction in a child's IQ.¹⁵ Thus, a child who is exposed to lead at age 1, but is not screened until age 2 or later, may suffer a multitude of physical and mental health problems, the extent of which depends on how early the lead poisoning is detected, halted and addressed.¹⁶

Health plans that focus primarily on 2-year-olds may be confusing the State DOH Quality Assurance Reporting Requirements (QARR), which require plans to report only the number of 2-year-olds screened each year to State DOH, with the lead screening law, which clearly requires screening at age 1 and 2. However, the QARR reporting standards should not be construed as a reflection of the plans' full statutory obligations. In short, all compliance practices and policies used by the plans for screening 2-year-olds should be applied with equal diligence to 1-year-olds.

In order to reinforce the importance of screening 1-year-olds, State DOH should consider amending the QARR reporting standards to require plans to report the number of 1-year-olds screened. Changing QARR to include one-year-olds would better enable the public, as well as State DOH and State Attorney General's office, to more closely and accurately monitor compliance with the law.

2. Plans Should Closely Monitor and Evaluate Network Provider Compliance

Information the Attorney General's Health Care Bureau received from the plans shows that a key component of the plans' lead screening compliance policies is their approach to monitoring the screening rates and practices of network providers.

Several plans take a decidedly hands-on approach by actively managing, engaging and overseeing network providers to promote higher lead screening rates. For example, New York Presbyterian-Community Health Plan (“NYP-CHP”) sends two mailings annually to providers containing the names and demographic backgrounds of all unscreened 2-year-old members, while simultaneously sending letters to the members’ parents urging them to schedule a screening. NYP-CHP also follows up with the provider to ensure that steps have been taken to contact and screen those children.¹⁷ Similarly, ABC Health Plan began using a Lead Screening Report Card in 2003, which rates its primary health care providers on lead screening in relation to statewide averages. Excellus identifies “high-risk” medical offices – those with high numbers of unscreened children – and works closely with them to develop more effective compliance plans. Preferred Care uses a Medical Record Documentation Review Process, whereby physicians are graded on several performance measures for the previous 24 months, including lead screening. Preferred Care providers that fall below a certain threshold must submit written “process improvement plans,” and are reviewed again in six months.

In order to improve provider oversight, health plans should create provider-specific lists each year of 1- and 2-year-old members who have not been screened for lead poisoning. Providers should be furnished with these lists and given a prescribed period of time to contact parents and schedule screenings. If, after the prescribed period of time, the children identified on the lists have still not been screened, the provider should be required to meet with the plan to discuss the efforts taken to screen these unscreened children and develop a detailed compliance plan to increase lead screening rates.

Health plans should also use provider lead screening as a performance criteria in the re-credentialing process for all family practitioners and pediatricians.¹⁸ Providers who do not meet a minimum lead screening standard should be required to address and improve their performance, or face sanctions by the plan.¹⁹

3. Plans Should Offer Incentives to Providers with High Screening Rates

Recognizing that the “carrot” is sometimes more effective than the “stick,” some plans offer financial incentives and recognition awards to providers who produce high childhood lead screening rates. MetroPlus established a Medical Performance Pool Distribution Program, which disburses monetary rewards to providers with high lead screening rates. The plan also holds an annual QARR Awards ceremony, which recognizes providers based on their QARR performance.²⁰ Other plans offer similar types of incentives and rewards.²¹

Health plans should offer some form of incentive or reward to providers for high screening rates. Incentives should be based on provider screening performance for both 1- and 2-year-old members. Such incentives not only provide a concrete benefit to compliant providers, but also send a strong message to providers and the public that the plan takes lead screening seriously.

4. Plans Should Offer Incentives to Members to Have Their Children Screened

Several plans offer gift certificates, usually to stores selling children’s merchandise, for parents who submit proof from their physician that their child has received all required immunizations and lead screenings.²² Health plans can offer incentives to parents who get their children screened at age 1 and 2. Incentives serve the dual purpose of educating parents about the importance of lead testing and increasing the likelihood that children will be tested.

5. Plans Should Conduct Regular Internal Assessments of Their Lead Screening Strategies

Several plans engaged in regular internal review to evaluate and improve their lead screening practices, yielding moderate to significant increases in annual childhood lead screening rates.²³ For example, recognizing that its Medicaid lead screening rates were well below average, HealthNow (Blue Shield of Northeastern New York) engaged in a comprehensive two-year focus study to identify shortcomings and develop new strategies to increase lead screening. Since implementing the recommendations from the study, HealthNow's lead screening rates have increased from 58% in 2001 to 66% in 2003.²⁴ Community Choice and ABC Health Plan engaged in a similar internal review and assessment, resulting in increases in screening rates.²⁵

All health plans, particularly those with low lead screening rates, should annually engage in a comprehensive review of their lead screening practices and policies.²⁶ At a minimum, such a process should (1) identify barriers to childhood lead screening, (2) assess the effectiveness of existing compliance strategies and (3) develop new strategies to achieve full compliance with the law.

6. Plans Should Explore Making Lead Testing More Accessible at Primary Care Physician Offices and Clinics

Health plans and providers reported that many physicians, instead of doing lead testing themselves, prefer to refer children to outside laboratories. Many parents may not use such referrals, leaving their children unscreened.²⁷ This reluctance to screen on-site may be due in part to the invasive nature of the most commonly used test, the venous test, which requires trained staff to draw blood from a young child's vein and which may also occupy a good deal of staff or physician time.²⁸

As a means of increasing lead screening rates, several lead poisoning and pediatric health coalitions in the state have discussed the more widespread use of less invasive testing procedures.²⁹ In particular, many recommend more widespread use of the finger stick capillary test, which is conducted by pricking the end of the child's finger with a lancet and pressing a capillary tube against the finger to draw in a small amount of blood. Affinity Health Plan has instituted a program that encourages physicians in high-risk communities to use the finger-stick test.³⁰ The relative ease with which this test is administered may lead more physicians to screen on-site.³¹

Additionally, the following testing options have demonstrated the potential to significantly increase the number of children screened:

- “Filter Paper” Finger-Stick Test. The Filter Paper Test is designed to allow physicians and staff to easily conduct the blood lead test in the office with minimal risk of contamination and minimal training.³² A Filter Paper Test Pilot Project in Kansas, funded by the Centers for Disease Control and Prevention (CDC), resulted in significant increases in lead screening rates, and both Minnesota and Wisconsin incorporate Filter Paper testing into their lead screening protocol.³³
- Portable Lead Screening Device. In 1997, the FDA approved the LeadCare In Office Test System, a portable, hand-held lead screening device developed through a grant from the CDC. The device allows quick and accurate screening and test results in a matter of minutes in the physician's office, and is also well-suited for community outreach settings, such as health fairs and mobile health vans, to screen children that might not otherwise be screened.³⁴ Pilot projects in Kansas and Washington have resulted in significant increases in lead screening rates at all locations using the portable lead screening device.³⁵

Given the success in other states, State DOH, in consultation with the CDC and health plans, might consider engaging in similar pilot projects to measure the efficacy of this type of test in New York.

7. Plans Should Engage in Early Member Outreach and Education

Early member outreach and education by the health plans appeared to be a noteworthy compliance strategy. Rather than waiting and reacting when a child misses a lead screening deadline, several plans pro-actively send educational material to members as soon as they become pregnant, and continue such education through birth and the child's first and second birthdays.

For example, pregnant members of ABC Health Plan receive a baby's bib along with a handy chart that allows parents to track the child's well-child care, including lead screenings. HIP Health Plan sends a "welcome card" when a member gives birth, as well as a refrigerator magnet containing important well-child information. Excellus identifies members when they become pregnant and immediately begins working with the obstetrician and the member to prepare for well-child care, including lead screening.³⁶ Other plans send attractive lead screening reminders, in some cases in the form of colorful, easy-to-read Happy Birthday cards, just before the child's first birthday, when lead screening should begin.³⁷ Suffolk Health Plan completes a Lead Risk Assessment Form with all pregnant members to address lead poisoning as early as possible.

Educational outreach efforts should begin early – preferably during pregnancy or immediately after delivery – to reinforce the important role of lead screening in routine well-child care and to prepare the new parent for a child's lead screenings at age 1 and 2. Plans should also send attention-grabbing lead screening reminders to members at the approach of each child's first and second birthdays. Follow-up reminders should be sent, and phone calls made, to members who do not respond to these reminders, and physicians should be notified and instructed to address lead screening with such members at the next well-child care visit. If a provider writes a referral for a member to be screened, but the member's parents do not follow-up with the referral

after a reasonable period of time, health plans might consider providing additional reminders by mail or telephone.

Several plans also carefully interview all new members to determine if lead screening has been done and to ensure proper follow-up if the child has not yet been screened.³⁸ For example, MetroPlus contacts all new members within 30 days of enrollment for an orientation. The orientation involves the completion of a Health Assessment Form, which includes lead screening, coupled with a review by Case Management staff to determine if further intervention is necessary.

With this in mind, health plans should complete health assessment forms for all new members that ask if their children have been screened for lead poisoning and provide lead poisoning education and reminders that children should be screened at age 1 and 2.

8. Plans Should Translate Educational Materials into Languages Its Members Use

Most plans translated educational materials into the more common non-English languages. HealthFirst translates its lead poisoning posters and educational materials into four languages – Spanish, Chinese, Russian and Creole – to serve its diverse member population.

Health plans should translate all lead poisoning educational and outreach materials into as many languages as is necessary to fully serve the plans' particular members.

9. Plans Should Educate Providers

There is no substitute for regular provider education about the importance and necessity of lead screening. All plans provide some level of provider education, with varying frequency and substance. The plans generally communicate lead screening information through provider newsletters, clinical practice guidelines and direct mailings. Others employ electronic transmissions to supplement the aforementioned methods.

At least twice a year, health plans should include articles and reminders in provider newsletters and Website postings about lead screening and lead poisoning. Individualized letters and e-mails should be sent to providers that encourage screening at age 1 and 2 within the context of routine well-child care. All provider education initiatives should emphasize two overriding principles: (1) that all children are at risk; and (2) the law requires that children must be screened at age 1 and 2, even though State DOH requires plans to report only the number of 2-year-olds screened.

Plans and health professionals reported that some physicians may interpret “lead screening” to mean “risk assessment,” and therefore may not be conducting blood lead tests on children deemed to be at lower risk of exposure to lead.³⁹ Therefore, plans should reiterate in provider practice guidelines and educational materials that screening means actually testing, and not simply risk assessment.

10. Plans Should Engage in Aggressive Community Outreach

Community outreach provides a great opportunity for plans to reach underserved populations and to identify ways to improve lead screening rates for the plans’ members. Some plans engage in significant community outreach.

For example, both major health plans in the Rochester area, Excellus and Preferred Care, are active participants in the Rochester Lead Coalition and Rochester Health Commission, and Excellus recently provided a multi-year grant to Rochester’s “Let’s Make Lead History” educational campaign.⁴⁰ Several Buffalo area health plans – HealthNow (Community Blue), Independent Health, Univera Community Health (Excellus) and Fidelis – participate in the Western New York Pediatric and Adolescent Coalition, which was formed to increase lead testing

and immunization rates among children.⁴¹ HealthFirst uses Community Outreach vans to conduct lead screenings and educational activities at community events attended by members, including the Children’s Health Street Festival, an annual event organized and attended largely by Latinos. Capital District Physicians Health Plan (CDPHP) conducts Wellness Workshops for members, one of which teaches the importance of proper nutrition in preventing or offsetting lead poisoning. Other plans coordinate lead outreach and education with other services provided to underserved populations, such as Women, Infants and Children (WIC) and Head Start.⁴²

Health plans should be involved with local public health groups, childhood lead poisoning coalitions and other environmental and preventive health organizations. Plans should also participate in health fairs, mobile health clinics and other community events to further educate the public about lead poisoning and the importance of lead screening. Given the ethnic and socio-economic disparities in lead screening statistics, plans should place particular emphasis on outreach to low-income ethnic neighborhoods.⁴³ Plans should also cover screening that takes place outside of the traditional primary care physician setting, such as health fairs, clinics, mobile health vans and other community events.⁴⁴

CONCLUSION

Universal lead screening at ages 1 and 2 is a key component of New York State’s efforts to control and ultimately eliminate childhood lead poisoning. HMOs and other health plans can and must play a pivotal role in these efforts by using their financial, technological and administrative resources to increase compliance with the state lead screening mandate.

One thing is clear: there is no “silver bullet” in childhood lead screening compliance; that is, no single plan initiative can be relied upon to generate high screening rates. Rather, a

comprehensive and ongoing approach to compliance must be employed, encompassing all of the major elements discussed in this document, including provider and member education, provider oversight, community outreach, and provider and member incentives. There is no room for complacency. Plans should regularly subject their compliance initiatives to rigorous internal review and evaluation in order to continually develop new and more effective lead screening strategies that are sensitive to, and effective for, the populations they serve.

Ultimately, the relationship between the health plan and its network providers will be a significant determining factor in compliance. Therefore, health plans, through their policies, communications and actions, must send a clear and consistent message to their providers that lead screening at both age 1 and age 2 is a high priority. This message must be reinforced by regular plan oversight and provider accountability.

The Best Practices compiled by the Attorney General are intended to help all Medicaid and Child Health Plus health plans to comply more fully with the universal lead screening mandate. The widespread adoption of these practices should significantly increase childhood lead screening rates in New York and substantially bolster the state and federal goal of eradicating childhood lead poisoning by the end of this decade.

ENDNOTES

1. www.oag.ny.gov/press/reports/getting_the_lead_out_report.pdf

The Attorney General's office has previously addressed the issue of childhood lead poisoning in a variety of contexts. Attorney General Spitzer led a multi-state effort that ultimately resulted in paint manufacturers agreeing in 2003 to place warning labels on all paint products explaining the risks of disturbing and preparing lead-contaminated surfaces. In 2003, the Attorney General also filed an amicus curiae brief in the case of New York City Coalition to End Lead Poisoning v. Vallone, 100 N.Y.2d 337 (2003), arguing successfully that the City Council did not properly consider the environmental impact of New York City Local Law 38 – a weak lead abatement law which lead advocates opposed – during its review and passage, in violation of the State Environmental Quality Review Act (“SEQRA”).

2. State law requires HMOs and providers to screen all children for lead poisoning, regardless of risk, at the age of 1 and 2. New York State Public Health Law Section 1370-c and Title 10 NYCRR, Part 67, Subpart 67-1.2(a).

3. The national goal of eliminating lead poisoning by 2010 set by the CDC has been adopted by the New York State Department of Health. New York State Department of Health, 2003, “Promoting Lead Free Children in New York State: A Report of Lead Exposure Status Among New York Children.”

4. Each year, the State DOH rates all health plans based on a number of performance measures, including the percentage of 2-year-olds enrolled in the plan who were screened for lead poisoning that year. Even though the law requires screening at age 1 and 2, State DOH does not require the plans to report the number of 1-year-olds screened. As a result, these rates do not fully and accurately reflect a plan's compliance with the law, but may be an indication of a plan's overall compliance efforts. The rates for individual health plans are then compared to the average statewide compliance rate for all New York health plans in a given year, and plans are placed in one of three categories: (1) significantly below the statewide average; (2) significantly above the statewide average; or (3) not significantly different from the statewide average. These ratings are reported annually in the New York State Department of Health Managed Care Plan Performance Reports.

5. Among Medicaid plans, average screening rates were 76% in 2000 and 2001, and then declined to 74% in 2002. (Since the Attorney General's report was released, State DOH has collected data from 2003, which will be reported in the 2004 Managed Care Plan Performance Report, that show that Medicaid screening rates are now at 75%, still below the 2000 rate of 76%.) Average Child Health Plus rates were 68% in 2000, 70% in 2001, and then back to 68% in 2002. Several individual plans cited in the Attorney General's report as performing well below average for this period showed increases in their lead screening rates for 2003.

6. 60% of U.S. children between 1 and 5 years of age with elevated blood lead levels are enrolled in Medicaid (“The Foundations of Better Lead Screening for Children in Medicaid,” The Alliance to End Childhood Lead Poisoning, citing U.S. General Accounting Office, “Medicaid: Elevated Blood Lead Levels in Children,” GAO/HEHS 98-78, February, 1998).

7. The Health Care Bureau requested all policies, communications, documents and contracts relating to childhood lead screening.

8. Generally, lead screening compliance activities fell into five categories: (1) provider and member education, (2) provider oversight, (3) compliance incentives (providers and members), (4) internal plan compliance review and evaluation, and (5) community outreach. Within these broad categories, several plans developed particularly inventive and proactive lead screening strategies, some unique to one or a few plans. Overall, some plans were strong in certain areas, but not others, while a select few displayed a strong commitment to compliance in all five areas during the period of the inquiry.

9. For example, ABC Health Plan, HealthFirst, Community Choice, Vytra, WellCare, Preferred Care, Excellus and NYP-CHP have systems that use screening data for 2-year-olds to track provider compliance. HealthNow reported that it is using lists of unscreened children between the ages of 12 and 24 months. HealthNow also requests the lead screening status of children in a letter sent to providers at 18 months of age. On a more systemic level, New York City Medicaid plans are required to enter into a Memorandum of Understanding with the City requiring additional lead screening compliance measures, yet the provider and member tracking and notification system set forth in the agreement relates only to 2-year-olds.

10. For example, in its letter to participating providers regarding lead screening, Vytra writes: “It is important to note that NYSDOH [New York State Department of Health] defines Lead Screening compliance as a child who has had a blood lead level performed prior to their 25th month of life.” Similarly, in a letter to members, Community Choice writes: “Children from birth to age 2 need to see their Primary Care Physician several times a year so that he or she can monitor your child’s growth and development, provide necessary immunizations and test your child for lead at least once before the age of 2.” (Emphasis added) ABC Health Plan’s Clinical Practice Guidelines confuse voluntary practice recommendations and State reporting standards with the State lead screening mandate by stating: “The recommendation from the Committee on Childhood Lead Poisoning Prevention is a screening lead blood test performed on all children enrolled in Medicaid or CHP at ages 1 and 2. According to QARR, at least one capillary or venous test should be performed and recorded by the end of the member’s 25th month of life.” HealthFirst’s “Childhood Lead Testing Quality Activities” policy states: “The purpose of this policy is to describe the process by which HealthFirst PHSP complies with New York State’s lead screening mandate (Public Health Law Section 1370-c) to ensure that its members are screened for lead poisoning or referred for such screening by age 2.” United HealthCare communicates to providers that screening must take place by the end of the child’s 24th month of life.

11. None of the provider incentives disclosed as part of this inquiry appear to include rewards for high screening rates for 1-year-olds. For example, MetroPlus, Community Choice and HealthFirst base incentives and awards on QARR reporting standards, which measure screening performance for 2-year-olds by health plans.

12. For example, ABC Health Plan and HealthFirst send reminders prior to the child’s second birthday.

13. P.J. Landrigan and J.E. Carlson, “Environmental Policy and Children,” and C.F. Bearer, “Environmental Health Hazards: How Children are Different from Adults,” *The Future of Children*:

Critical Issues for Children and Youths, Vol. 5, No. 2 - Summer/Fall 1995; see also “Why Children are at Higher Risk,” Alliance for Healthy Homes Website at www.afhh.org

14. Eliminating Childhood Lead Poisoning in New York State by 2010 (Working Draft for Discussion), New York State Department of Health, June 2004, citing Silbergeld, E.K., “Preventing Lead Poisoning in Children,” Annual Review of Public Health, 18:187-210, 1997.
15. B.P. Lanphear et al, “Intellectual Impairment in Children with Blood Lead Concentrations Below 10 ug per Deciliter,” New England Journal of Medicine, Vol. 348: 1517-1526, No. 16, April 17, 2003. See also, EPA, “America’s Children and the Environment: Measures of Contaminants, Body Burdens, and Illnesses,” 2003.
16. Depending on the severity and length of exposure to lead, children can suffer neurological impairment, learning disabilities, attention deficits, behavioral problems, growth delays, dental caries, hearing loss, hypertension, anemia, kidney malfunction and, in some severe cases, encephalopathy. CDC, “Second National Report on Human Exposure to Environmental Chemicals,” (2003). See also, EPA, “America’s Children and the Environment: Measures of Contaminants, Body Burdens, and Illnesses,” (2003); Weitzman, Michael, MD, “Childhood Lead Poisoning and Managed Care,” Journal of Public Health Management and Practice, Vol. 4, No. 1, January, 1998; and Lanphear, Bruce P., M.D., MPH, “The Paradox of Lead Poisoning Prevention,” Science, 281 (5383): 1617.
17. These measures are part of NYP-CHP’s comprehensive Children Immunization/Lead Outreach Preventive Health Program.
18. Preferred Care established such a policy.
19. HealthFirst allows for sanctions in its Medical Record Review policy, which tracks provider performance, including lead testing.
20. As discussed earlier, these awards are based only on the provider’s screening performance for 2-year-olds, thus downplaying the corresponding obligation to screen at age 1.
21. For example, MetroPlus, Community Choice and HealthFirst offer financial incentives for high lead screening numbers.
22. For example, HIP, NYP-CHP, Community Choice, ABC Health Plans and HealthFirst provide some reward, either in the form of money or a gift certificate, upon providing proof of lead screening.
23. For example, HealthNow, Community Choice, ABC Health Plan, HealthFirst and Empire HealthChoice engage in various forms of internal review and assessment.
24. Although 66% is still considerably below the statewide average rate of 75% for 2003 and thus still needs improvement, this particular effort is commendable in that it manifests the principle that health plans should continually strive to increase their lead screening rates.
25. In its document disclosure pursuant to the Attorney General’s inquiry, Community Choice reported an 84% Medicaid lead screening rate for 2003, up from 63% and 64% in 2001 and 2002, respectively, after a “QARR Root Cause Analysis and Action Plan.” ABC Health Plan evaluated and

revised its lead screening policies and practices, resulting in a Medicaid screening rate of 71% in 2003, up from 63% and 62% in 2001 and 2002, respectively.

26. This process is commonly known in the health insurance industry as “Root Cause Analysis and Action Plan.”

27. HealthNow identified this problem as part of a two-year study on lead screening among Medicaid plan members.

28. Interview with Philip J. Landrigan, M.D., M.Sc., Professor of Pediatrics and Chair of the Department of Community and Preventive Medicine at Mount Sinai School of Medicine (November 18, 2004). Dr. Landrigan is a current member, and former Chair, of the New York State Childhood Lead Poisoning Prevention Advisory Council and is widely published in peer-reviewed medical journals, particularly on the subject of childhood exposure to environmental toxins such as lead.

29. For example, the Western New York Pediatric/Adolescent Coalition, a coalition of health professionals that includes representatives from area health plans, has already discussed efforts to promote the more widespread use of the finger-stick test by physicians. Minutes of meeting of January 26, 2004 at New York State Department of Health Offices in Buffalo, New York. Additionally, the Capital Region Lead Program coalition, which includes several area health plans, has discussed and monitored efforts to promote the greater use of the Filter Paper test. Minutes of meeting of February 11, 2004 at Albany Medical Center Department of Pediatrics, Albany, New York.

30. Health Plan Achievement Awards 2003 & 2004, New York Health Plan Association.

31. The American Academy of Pediatricians issued a statement in 1998 which concluded that the capillary finger-stick system can approach the accuracy level of the venous system with proper anti-contamination procedures, calling the capillary test a “practical screening alternative.” American Academy of Pediatrics: Screening for Elevated Blood Lead Levels, Committee on Environmental Health, Pediatrics, Vol. 101, No. 6, June 1998, 1072-1078. See also, Schonfeld, D.J., “Screening for Lead Poisoning by Finger-Stick in Suburban Pediatric Practices,” Archives of Pediatrics and Adolescent Medicine, Vol. 149, No. 4, June 1998, 1072- 1078, and Schlenker, T.L., “Screening for Pediatric Lead Poisoning: Comparability of Simultaneously Drawn Capillary and Venous Blood Samples,” Journal of the American Medical Association, 271: 1346-1348, 1994, and Parsons, P.J., “Screening Children Exposed to Lead: An Assessment of the Capillary Blood Lead Fingerstick Test,” Clinical Chemistry, 43: 302-311, 1997.

State regulations indicate a preference for venous testing, while also allowing the finger-stick test if certain anti-contamination steps are taken. Title 10 NYCRR, Part 67, Subpart 67-1.3(b). The regulations require a follow-up venous test to confirm an elevated blood lead level from a capillary test, thus providing a safeguard for false positives if a blood specimen is contaminated. See Title 10 NYCRR, Part 67, Subpart 67-1.2(a)(8).

32. Verebey, Karl, “Filter Paper-collected Blood Lead Testing in Children,” Clinical Chemistry, 46: 1024-1028, 2000 (The primary advantages of the Filter Paper test are: (1) only a small amount of blood is taken; (2) the test is more easily administered and less traumatic for children; (3) less staff training is needed; and (4) specimens are stable.) See also, Yee, H.Y., “An Improved Capillary Blood-Filter

Paper-Graphite Furnace Atomic Absorption Spectrometric Method for Lead Screening,” *Journal of Analytical Toxicology*, 21, 142-148, 1997; Stanton, Noel V., et al, “Evaluation of Filter Paper Blood Lead Methods: Results of a Pilot Proficiency Testing Program,” *Clinical Chemistry*, 45: 2229-2235, 1999.

The CDC has taken an official position that the Filter Paper test is an acceptable method of testing for lead poisoning, as long as the lab testing the blood sample participates satisfactorily as a Clinical Laboratory Improvement Amendment (CLIA)-certified facility. Department of Health and Human Services Position Statement, March 9, 1999 letter to health care providers and laboratories. Thus, health plans, in conjunction with DOH, will need to work with providers and labs to ensure proper testing and laboratory standards are met when the Filter Paper test is used.

33. “Kansas Childhood Lead Prevention Program,” Annual Report, January 1, 2001 - December 31, 2001, found at www.kdhe.state.ks.us (Kansas Filter Paper and Portable Lead Screening Device pilot projects resulted in significantly higher screening numbers among participating physicians and clinics); “The Foundations of Better Lead Screening for Children in Medicaid,” Alliance to End Childhood Lead Poisoning, found at www.afhh.org (State of Washington Portable Lead Screening Device Pilot Project resulted in significantly higher lead screening rates); Minnesota Blood Lead Surveillance Data Report, 2003, Minnesota Department of Health (State uses Filter Paper Test as an acceptable screening method); Wisconsin State Laboratory of Hygiene Filter Paper Lead Proficiency Program (State uses Filter Paper and regularly tests its proficiency).

34. Shannon, M. and Rifai, N., “The Accuracy of a Portable Instrument for Analysis of Blood Lead in Children,” *Ambulatory Child Health* (1997) 3: 249-254 (clinical accuracy rates compare favorably with other lead measurement techniques); Interview with Philip J. Landrigan, M.D., M.Sc., Professor of Pediatrics and Chair of the Department of Community Medicine at Mount Sinai School of Medicine, on November 18, 2004. Dr. Landrigan stated that, based on his broad experience, the portable lead screening device is very effective, accurate and useful.

State DOH and health plans would need to work closely with federal regulatory entities to ensure compliance with federal laboratory requirements under the Clinical Laboratory Improvement Amendments of 1998 (CLIA). The health plans, preferably in conjunction with State DOH, can apply to federal regulators for approval of plan laboratories or specific provider locations to determine if such testing increases screening rates.

The company that developed the LeadCare device has recently developed a newer version of the instrument, which is currently before the FDA for review. The FDA is considering waiving the CLIA laboratory standards for this newer version in order to allow the more widespread use of the device at provider locations.

35. The State of Kansas received a CLIA certificate for multiple laboratory and provider sites to use the LeadCare instrument. All locations saw a dramatic increase in Medicaid Screening rates (see “Kansas Childhood Lead Prevention Program,” Annual Report, January 1, 2001 - December 31, 2001, found at www.kdhe.state.ks.us). Additionally, the State of Washington instituted a similar pilot project which also resulted in significantly higher lead screening rates (see “The Foundations of Better Lead Screening for Children in Medicaid,” Alliance to End Childhood Lead Poisoning, found at www.afhh.org)

36. MetroPlus sends a “MetroMom” mailing to all expectant mothers, including lead screening information. HealthNow sends an After Baby Arrives folder to pregnant members, which includes lead screening information.
37. Excellus, HIP and HealthNow send colorful birthday reminders beginning just before age 1 and also just before 2. This is important because the law requires screening at 1 and 2. (HIP makes follow-up calls at 18 months of age if the child has not yet been screened; HealthNow is considering combining its immunization, lead screening, dental and well-child educational interventions into single interventions that will take place at birth, 1, 2, 4, 11 and 17 years of age.) ABC and HealthFirst send reminders at age 2, with HealthFirst also making direct telephone contact with the member.
38. New York Presbyterian - Community Health Plans, MetroPlus and Suffolk Health Plan instituted particularly aggressive new member health assessment and follow-up policies.
39. In its internal lead practices focus study, HealthNow identified this problem and changed all wording on preventive health guidelines from “screening” to “testing.” Empire HealthChoice also noted this problem.
40. Excellus and Preferred Care were noted in the Attorney General’s July 2004 report for consistently reporting high childhood lead screening rates well above the average statewide rates for the period of 2000 to 2002. Both plans provided funding for the Rochester Lead Summit, an educational conference organized by Lead Free By 2010, the Rochester area lead poisoning coalition.
41. HealthNow (Blue Shield of Northeastern New York), CDPHP and MVP participate actively in the Capital Region Lead Coalition to discuss ways to increase lead screening.
42. Community Choice identified this strategy in its assessment and action plan. Additionally, the Minnesota Department of Health had success screening children through the WIC program. Minnesota Blood Lead Surveillance Data Report, 2003, Minnesota Department of Health.
43. Even though overall 2.2% of children in the United States under 5 are lead-poisoned, 8% of low-income children, 11.3% of African-American children and 21.9% of African-American children living in pre-1946 housing are lead-poisoned. Hispanic children are twice as likely to be lead poisoned. In New York City, 95% of lead-poisoned children in 2001 were African-American, Hispanic or Asian. See CDC, “Surveillance for Elevated Blood Lead Levels Among Children - United States, 1997-2001” Morbidity and Mortality Weekly Report, Vol. 52, SS-10, September 13, 2003; CDC, “Update: Blood Lead Levels - United States, 1991-1994,” Morbidity and Mortality Weekly Report, Vol. 47, No. 7, February 21, 1997; Quintero-Somaini, Adrianna and Quirindongo, Mayra, “Hidden Danger: Environmental Health Threats in the Latino Community,” Natural Resources Defense Council (October 2004); and New York City Department of Health and Mental Hygiene, “Preventing Lead Poisoning in New York City,” Annual Report, 2001.
44. Excellus covers screening in non-traditional settings, such as at health fairs and other community health events.