ALLIANCE FOR HEALTHY HOMES

Protecting Children from Lead and Other Environmental Health Hazards

Stuck in Neutral

States Neglect Lead Testing Duty to Children Served by Medicaid

ACKNOWLEDGEMENTS

The primary author of this report is Anne M. Wengrovitz, MPH. The author thanks the following individuals for their collaboration, expert advice, or assistance in reviewing, formatting, and finalizing this report.

Jane Perkins, National Health Law Program
Eileen Quinn, Brian Gumm, and Ralph Scott, Alliance for Healthy Homes

Note: The working title of this report was "Lead Screening for Children Served by Medicaid: Are States Measuring Up?"

EXECUTIVE SUMMARY

The Alliance for Healthy Homes has completed a new analysis of state data on lead screening services provided to children in Medicaid, who are considered at high-risk for lead poisoning as a group. The data were contained in the "Form 416s" that are submitted annually by state Medicaid agencies to the Centers for Medicare and Medicaid Services (CMS). CMS requires states to report key information to track the preventive screening and health care services being provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) portion of the Medicaid program.

Distressingly, these data confirm that states are failing to deliver the lead screening tests required by federal law, and that efforts to improve lead screening rates for high-risk children served by Medicaid are yielding barely detectable progress. Despite widespread outrage over low lead screening rates documented in a 1998 General Accounting Office (GAO) report, rates are still low. Key findings include these:

- Most Medicaid children, especially those at the youngest ages, receive at least some preventive services each year that are billed by states as EPSDT screens. In FY 2003, 83% of enrolled infants under age 1 and 70% of children aged 1 to 2 received at least one EPSDT screening.

- Most one- and two-year old children served by Medicaid are not receiving required lead screening tests. About 24% of Medicaid enrolled children in the 1 - 2 year old age group received a lead screening test in FY 2003. Although the data herein show a slight trend upward (from 16% in FY 1999 to 24% in FY 2003), remarkably little progress is shown from GAO's 1998 estimates.

- The problem is NOT that children in Medicaid do not receive regular preventive care. The problem is that children who go to the doctor are still not receiving the required lead screening tests. Barely one in three children (34%) aged 1 - 2 receiving preventive care received a blood lead screening test as part of their screening in FY 2003.

There are several important limitations to the conclusions that can be drawn from analyzing the Form 416 data. Among others, these include the facts that the data are entirely self-reported by states with no means of validating their accuracy and that the forms made available by CMS do not include all states for each year of the analysis. Despite these caveats, it is clear that the absolute number of lead screening tests provided to children enrolled in Medicaid remains unconscionably small – and that the vast majority of young children served by Medicaid still are not being screened for lead poisoning. To improve the delivery of lead screening services to children at highest risk for lead exposure and to trigger the environmental follow-up services necessary to control lead hazards before they poison additional children, the Alliance for Healthy Homes recommends the following three steps:

1) **Put CDC in Charge of Medicaid Lead Screening** — The utter failure of CMS to provide effective leadership, oversight, or enforcement of its own lead screening policy demands a new approach. The Alliance recommends that the Secretary of Health and Human Services (HHS) charge the Centers for Disease Control and Prevention's (CDC) Lead Poisoning Prevention Branch with reviewing current Medicaid policy and practice for lead poisoning and developing a set of

remedial action steps to be taken by CMS and state Medicaid agencies, along with an implementation schedule and evaluation plan.

2) **States Should Adapt Lead Screening Strategies Proven Effective in Other States** — Three strategies should be considered by all states struggling with low screening rates for Medicaid enrollees. First, State Medicaid agencies should review the screening performance of individual managed care organizations and health care providers and provide specific feedback to these health care providers on their individual lead screening rates. Second, states should consider using monetary incentives (or disincentives) to reinforce lead screening performance. Third, state Medicaid agencies should provide reimbursement for lead screening provided at alternative sites where Medicaid-enrolled children present for services, such as WIC program sites.

3) **Give CDC Badly-Needed Resources for Lead Poisoning Prevention** — Funding for CDC's Lead Poisoning Prevention Branch should be increased from $36.4 million to $60 million to reflect its expanded leadership responsibility for lead elimination, primary prevention, and now Medicaid screening. The CDC CLPPP branch has experienced modest funding cuts over ten years, despite increased responsibilities to redirect—and then support—the fundamental public health strategy for lead poisoning prevention (primary prevention) during this time period. Most of CDC's lead poisoning funds are distributed to states and cities with the most significant lead poisoning problems. At present, CDC and its partners are engaged in a concerted effort to develop and implement strategic plans to eliminate childhood lead poisoning by 2010, but they have not received increased resources to support this vital one-time initiative. Adding responsibility for oversight of Medicaid screening and treatment would be a natural extension of CDC's current leadership role in CLP prevention, but requires an appropriate investment of federal resources to support this additional function.

INTRODUCTION

The Alliance for Healthy Homes has completed a new analysis of state data on lead screening and preventive health care services provided to children in Medicaid. Due to the considerable coincidence of poverty and lead poisoning, Medicaid-enrolled children are considered at high-risk for lead poisoning as a group. The data in this report confirm that states are failing to deliver the lead screening tests required by federal policy, and that efforts to improve lead screening rates for high-risk children served by Medicaid are yielding barely detectable progress.

Under federal law, children enrolled in Medicaid are entitled to receive a federally defined set of preventive screening services, along with any necessary diagnostic or treatment services identified through the screening; this Medicaid benefit is called "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT). Core EPSDT benefits are defined in federal law and regulation. EPSDT is administered by the Centers for Medicare and Medicaid Services (CMS), (formerly the Health Care Financing Administration), an agency of the US Department of Health and Human Services.[1] Program requirements are set out in the State Medicaid Manual, which serves as CMS's enforceable guidance document for states administering Medicaid. Federal law requires that EPSDT provide comprehensive physical examinations, including laboratory services, and vision and dental screening, according to an age-specific schedule. Current EPSDT screening policy requires children in Medicaid to receive a blood lead screening test at ages 12 and 24 months, and one screening test up to age 72 months if there is no record of a child having been screened by age 2.

To monitor EPSDT services provided by states to Medicaid enrollees, CMS requires states to report certain data each year on its Form 416. Since FY 1999, the form has included a requirement to report data on lead screening tests provided. In response to a joint FOIA request by the National Health Law Program and the Alliance, CMS provided paper copies of completed state Form 416s for FY 1999-2001.[2] Some months later, CMS posted corrected state forms for FY 2001 and state submissions for FY 2002 and FY 2003 on its website (http://www.cms.hhs.gov/medicaid/epsdt/default.asp). This report analyzes those forms that were publicly posted as of May 5, 2005.

[1] A report on Medicaid from the House Ways and Means Committee provides a detailed description of the Medicaid program; *see 2004 Green Book - Overview of the Medicaid Program*. Accessed on October 27, 2004 at http://www.healthlaw.org/pubs/2004.greenbook.medicaid.pdf

[2] CMS's website now posts the completed CMS Form 416s analyzed in this report. States' initial submissions are due to CMS in April following the end of the Federal fiscal year (Sept. 30). CMS staff then review submissions and work with states to correct errors, deferring public release of the forms until the correction process is completed. Thus, there is normally a considerable lag time between the end of the data collection period and the time that CMS will release Form 416s.

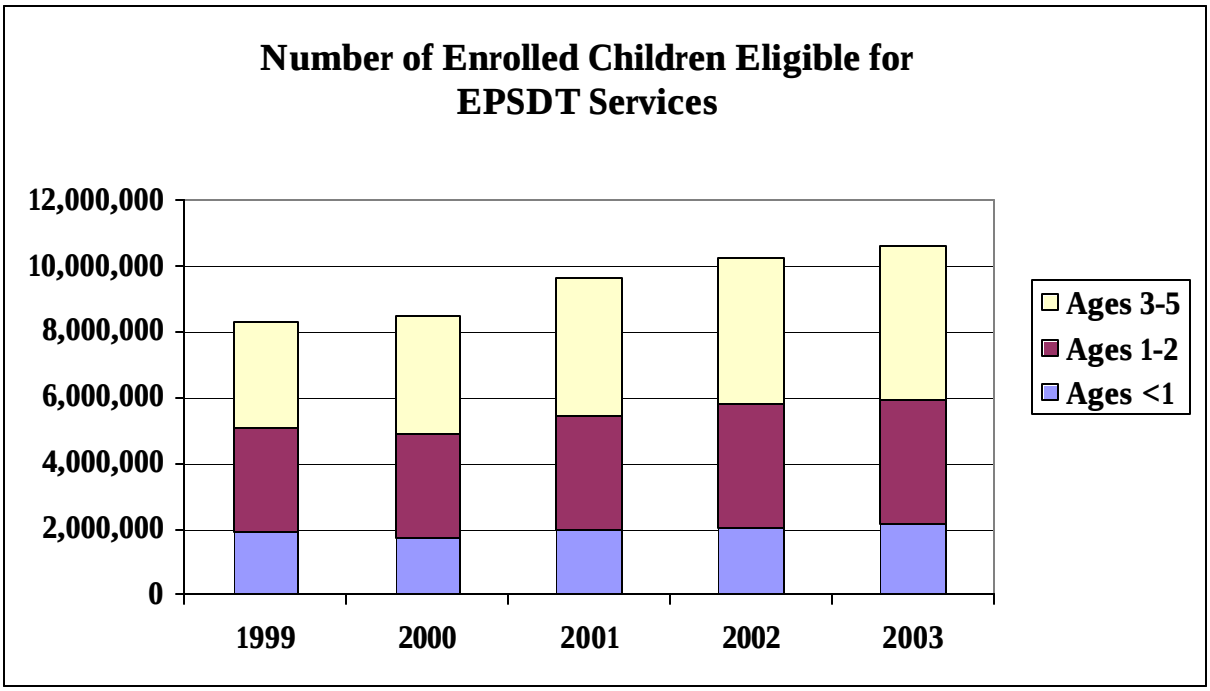
FINDINGS

Enrollment rates

Medicaid is enormously important as the principal provider of health insurance coverage for low-income children. Medicaid covers more than 1 in 4 children nationwide—over 25 million children under age 19 in 2003.[3]

As a group, Medicaid children in the US are a high priority for lead screening services due to their elevated risk for lead poisoning. At the national level, data consistently show that, as a group, young children enrolled in or eligible for Medicaid are at increased risk for lead exposure. For example, an analysis of 1998 - 2004 data from the National Health and Nutrition Examination Survey (NHANES) by the Centers for Disease Control and Prevention (CDC) estimated that up to 93% of children with EBLLs ≥20 were Medicaid-eligible.[4]

The data described in this report cover only children younger than 6 years of age, and only from those states for whom Form 416s were provided by CMS – about 10.6 million children ages 0 – 5 in FY 2003. (From Form 416: Line 1)



Participation Rates

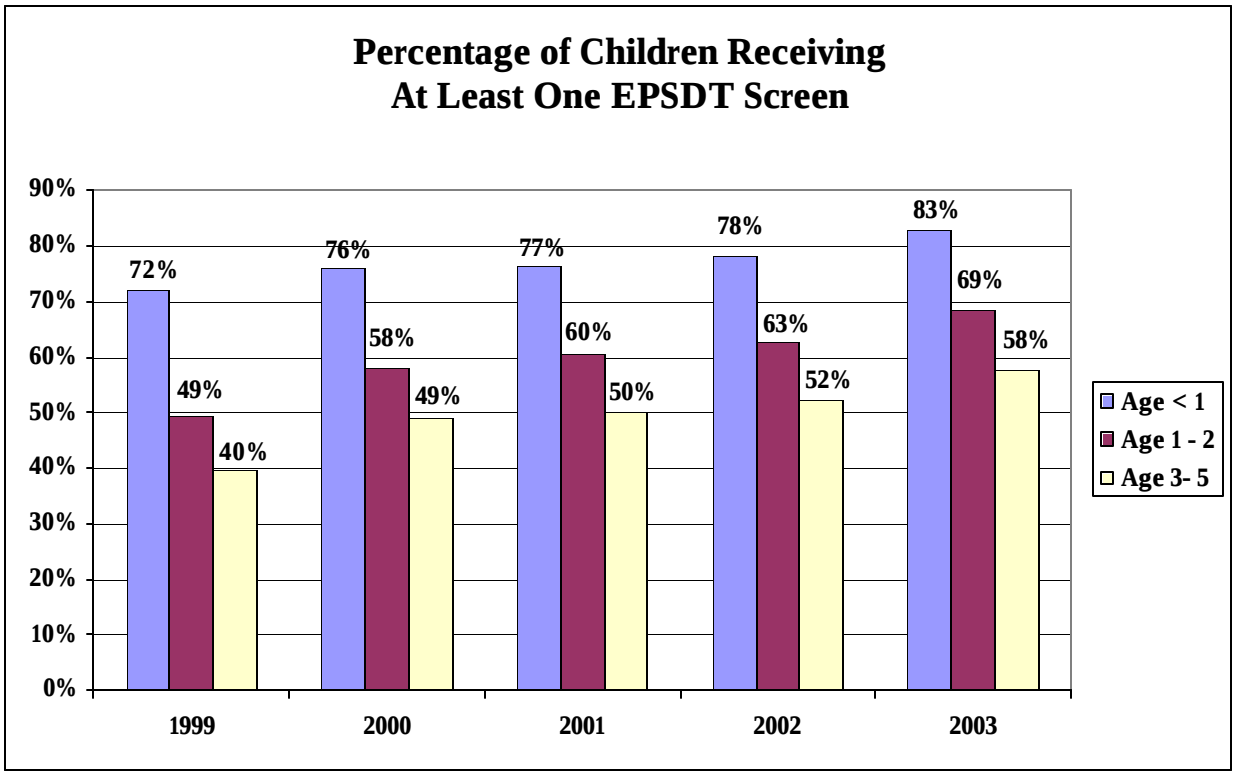
Most Medicaid children, especially those at the youngest ages, receive at least some preventive services each year that are billed by states as EPSDT screens. In FY 2003, 83% of enrolled infants under age 1 and 70% of children aged 1 to 2 received at least one EPSDT screening.

---

[3] A September 2004 fact sheet on ***Health Coverage for Low-Income Children*** is available at: http://www.kff.org/uninsured/upload/Health-Coverage-for-Low-Income-Children-September-2004-UPDATE.pdf Accessed August 2, 2005.

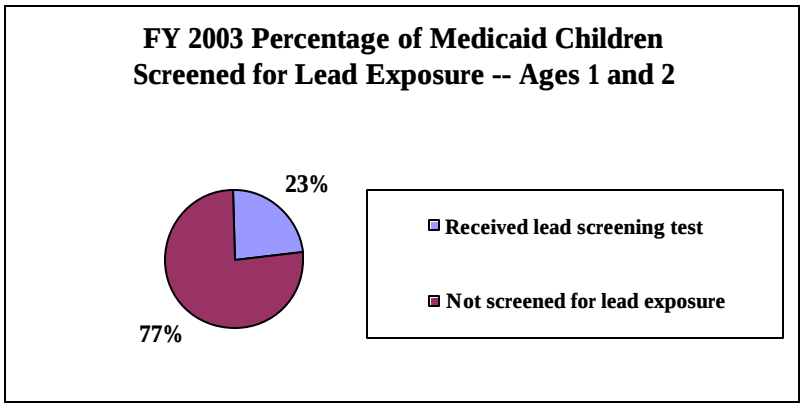
[4] Rachel B. Kaufmann, Timothy L. Clouse, David R. Olson, and Thomas D. Matte, Elevated Blood Lead Levels and Blood Lead Screening Among US Children Aged One to Five Years: 1988-1994 Pediatrics 106(6): December 2000.

However, as children age, they receive fewer preventive screens on average. Just 59% of enrolled children ages 3 to 5 received an EPSDT screen in FY 2003. (From Form 416: Line 9/Line 8)



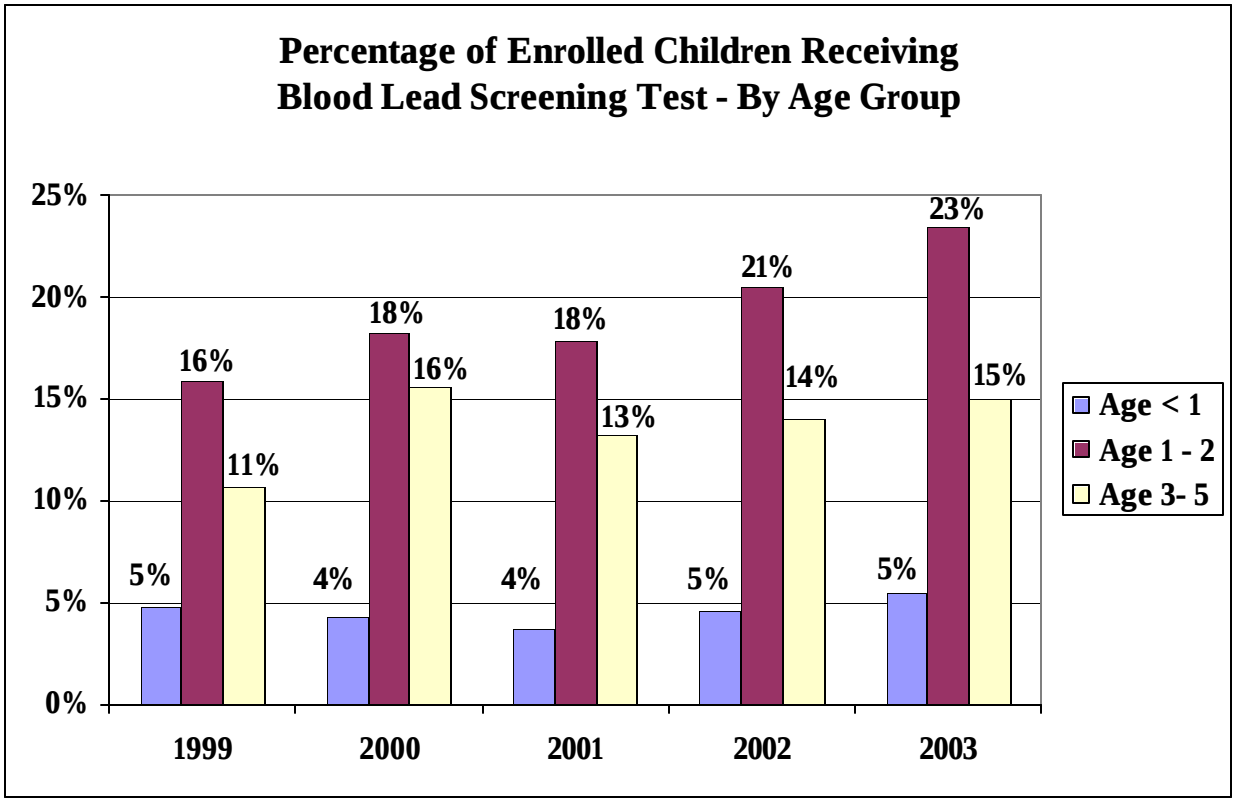
Lead Screening Rates

In 1998, GAO published an analysis of screening data for the years 1991-1994 estimating that only about 19% of Medicaid-enrolled children under age 5 were being screened for elevated blood lead levels (EBLs). In the years since the GAO report was published, CDC, states, advocates, and experts have worked aggressively on multiple fronts to improve policies, programs, and practices for lead screening of this high-risk group. However, the most recent data on this point is troubling, showing very limited progress in screening rates nationally.

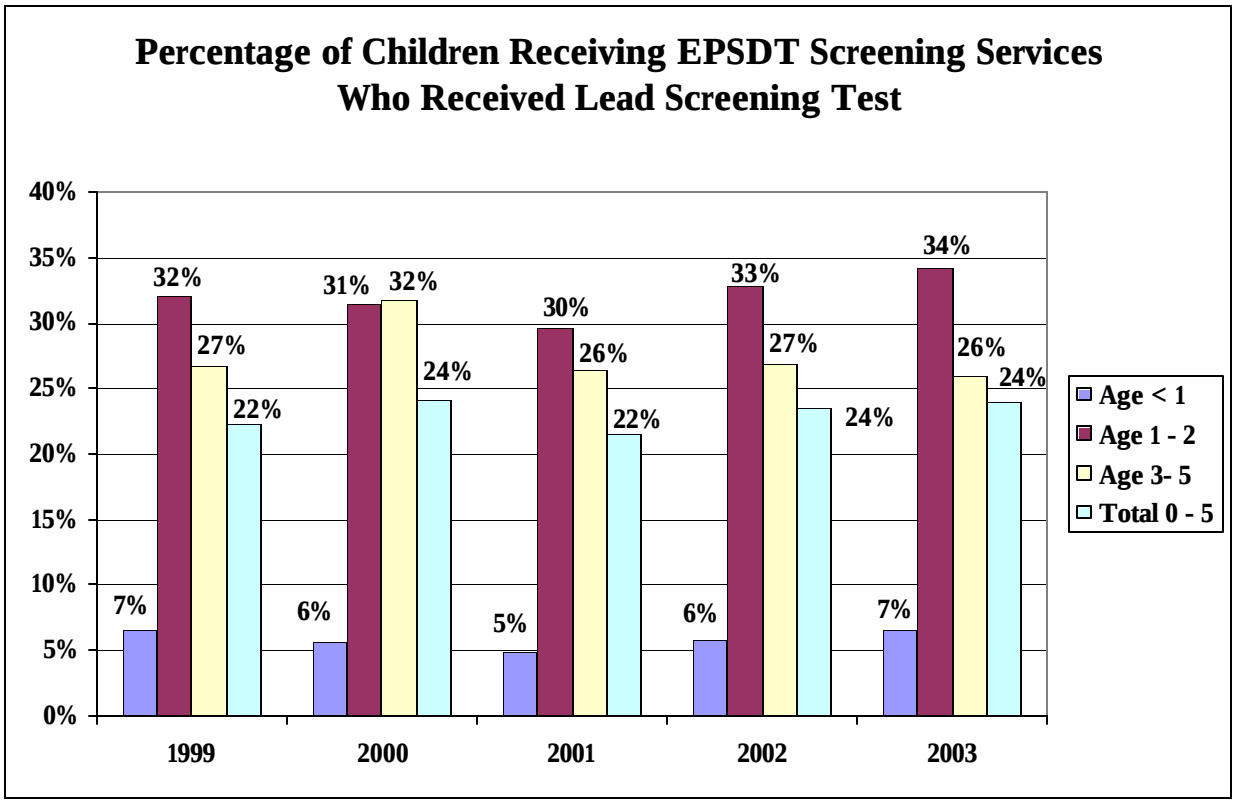


According to states' self-reported data, about 24 % of Medicaid enrolled children in the 1-2 year old age group received a lead screening test in FY2003. (From Form 416: Line 14/Line 8)

Since not all children receive their lead screening tests precisely at the scheduled age for testing (12 and 24 months), lead screening tests for all young children are presented here by age. While rates are highest for children ages 1 and 2, it is clear that most young children served by Medicaid are still not being screened for lead poisoning.



Some have suggested in the past that lead screening rates are low because Medicaid-enrolled children do not seek regular preventive care. However, the data clearly refute this explanation. In fact, barely one in three children (34%) ages 1 - 2 receiving preventive care billed as an EPSDT screen received a blood lead test as part of their screen in FY 2003. (From Form 416: Line 14/Line 9)



Discussion

The most significant finding of this analysis is that most Medicaid-enrolled children (76% of children aged 1 and 2) are not being tested for lead exposure as required by federal policy—a finding that is a major disappointment after significant policy, program, and advocacy efforts to improve delivery of lead screening to this high-risk group in the eight years that have passed since the publication of GAO's 1998 analysis.

Some states will claim that the Form 416 data they provided under-represents their actual screening performance for various reasons, and they may be partially correct in this regard. Recent data puts the nationwide number of Medicaid children screened higher than reported on the Form 416s. The 1999-2002 NHANES survey found that 42.7% of Medicaid-enrolled children (ages 1 to 5) reported that they had received a blood lead test previous to their NHANES examination. This progress most likely has been driven by improvement in screening rates in a few places that have linked their state lead surveillance system with their state Medicaid enrollment database (e.g., Rhode Island, Wisconsin, Chicago).[5,6]

However, whether the data makes them look inadvertently better or worse than reality, states reporting inaccurate data on the 416s actually face a larger hurdle than their more accurate peers in improving lead screening, given the central importance of data to successful screening programs. If states cannot accurately identify who has been screened or provide an accurate head count of

[5] Centers for Disease Control and Prevention. *Blood Lead Levels --- United States, 1999--2002*. MMWR 2005;54(20):513-516.

[6] Alliance for Healthy Homes, *Building Blocks for Primary Prevention*, 2005. Accessible online at http://www.afhh.org/buildingblocks/BB%20Intro%20Level%20One.asp. Accessed August 2, 2005.

services provided, states still have a long way to go. (Without good lead testing data, states may also be paying managed care organizations for services not being provided, but that issue is beyond the scope of this paper.) The Form 416 reporting requirement for lead screening has now been in place since FY 1999, so states have had ample time to revise their data collection or management practices.

Another important finding was that lead screening is not being provided to Medicaid children who seek other medical care. In 2003, states reported that 70% of children ages 1 and 2 received at least some services billed as EPSDT services, yet lead testing rates are much lower.

There are important limitations to the conclusions that can be drawn from analyzing the Form 416 data used in this report. First, the data are entirely self-reported by states, making it impossible to independently assess the validity or accuracy of the information. Medicaid enrollment data, for example, is notoriously difficult to track and analyze, in large part due to state Medicaid eligibility rules that result in frequent enrollment changes as individuals lose, gain, or regain eligibility. Second, states may have difficulty collecting data from managed care organizations and laboratories that provide services under contract to the state Medicaid agency. Third, it can be difficult to determine whether apparent changes in delivery of services reflect actual variation in service delivery or anomalies in data reporting, including age classification issues. (For example, some lead screens may be provided just before a child's 1st birthday or just after the 3rd birthday, thereby narrowly excluding a test from the 1-2 year age group). Fourth, it is difficult to use this data for trend analysis since not all states' forms are included for every year, and especially since data for some large states is missing for some years (e.g., New York, Texas). Finally, the 416 data make it impossible to determine what services were delivered to individual children. For example, it is not possible to tell whether the children who received lead screening tests were the same children, different children, or some of the same children as those who received EPSDT screening tests, nor is it possible to determine whether multiple tests for the same child are counted. Despite these caveats, it is clear that the absolute number of lead screening tests provided to children enrolled in Medicaid remains unconscionably small and that the vast majority of young children served by Medicaid still are not being screened for lead poisoning.

RECOMMENDATIONS

In response to these findings, the Alliance recommends three priority actions to improve lead screening for children served by Medicaid and to trigger the environmental follow-up services necessary to control lead hazards before they poison additional children.

1) **Put CDC in Charge of Medicaid Lead Screening** — As part of an earlier national class action settlement agreement[7], HHS stipulated that CDC's expertise in lead poisoning would guide CMS (then HCFA) implementation of Medicaid's EPSDT lead screening requirements. Since then, CMS has accepted CDC guidance with respect to certain technical aspects of its screening policy (such as appropriate ages for screening), but CMS has fallen woefully short in other areas. The agency's longstanding and continued track record of inadequate lead screening speaks for itself. And, CMS leadership has been lacking. Since 2001, CMS has remained largely silent on lead screening, except to consider reducing the amount of lead screening required. In fact, after requesting assistance from CDC's Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) and holding numerous staff level meetings, CMS never adopted or even responded to the ACCLPP's 2002 recommendations for updating Medicaid screening policies to permit targeted screening strategies. This utter failure of CMS to provide meaningful leadership, oversight, or enforcement of its own policy demands a new approach. The Alliance therefore recommends that the Secretary of HHS give CDC responsibility for overhauling the federal approach to lead screening of children enrolled in Medicaid. Specifically, the Secretary of HHS should charge CDC's Lead Poisoning Prevention Branch with reviewing current Medicaid policy and practice for lead poisoning and developing a set of remedial action steps to be taken by CMS and state Medicaid agencies, along with an implementation schedule and evaluation plan.

2) **States Should Adopt Lead Strategies Proven Effective in Other States** — Over the past decade, some states have devised successful approaches to improve lead screening rates among the Medicaid population. In particular, three strategies should be considered by all states struggling with low screening rates.

- First, state Medicaid agencies should review the screening performance of individual Medicaid managed care organizations (MCOs) and health care providers and provide specific feedback to these health care providers on their individual lead screening rates. A particularly effective strategy, which has been implemented in Rhode Island and Wisconsin, is for the Medicaid agency to use electronic data systems to generate lists of individual Medicaid children who have not received lead screening tests and provide the names to the children's health care providers and/or MCOs. Usually, this approach requires matching data from the state lead surveillance system with data from the state Medicaid system. (CDC has supported state efforts to build this capability and requires its current grantees to do so.)

- Second, states should use monetary incentives (or disincentives) to reinforce lead screening performance. In Maine, the Primary Care Providers' Incentive Program (PCPIP) provides financial incentives to health care providers for serving Medicaid beneficiaries and for

[7] *Thompson v. Raiford*

achieving certain screening targets, including blood lead screening.[8] In Minnesota, health care plans are eligible for incentive payments for improvements in lead testing rates. However, the state also withholds 5% of compensation from contracts between health plans and the Department of Human Services (DHS). Specific targets for increasing lead screening in high risk populations are a significant part of the measures used to determine the amount of the withhold that may be "earned" back by the plans.[9]

- Third, state Medicaid agencies should provide reimbursement for lead screening provided at alternative sites where Medicaid-enrolled children present for services, such as WIC program sites. In recent years, WIC programs have played a limited role in supporting lead screening for various reasons, but CDC has increased efforts to collaborate with WIC. Several jurisdictions (i.e., Chicago, Newark, Ohio, and Wisconsin) are participating in a CDC pilot program to capture Medicaid funds for lead screening provided at WIC sites.

3) **Give CDC Badly-Needed Resources for Lead Poisoning Prevention** — Funding for CDC's Lead Poisoning Prevention Branch should be increased from $36.4 million to $60 million to reflect its expanded leadership responsibility for lead elimination, primary prevention, and now Medicaid screening. The CDC CLPPP branch has experienced modest funding cuts over ten years, despite having the responsibility to redirect—and then support—the fundamental public health strategy for lead poisoning prevention (primary prevention) during this time period. Most of CDC's lead poisoning funds are distributed to states and cities with the most significant lead poisoning problems. At present, CDC and its partners are engaged in a concerted effort to develop and implement strategic plans to eliminate childhood lead poisoning by 2010, but they have not received increased resources to support this vital one-time imitative. Adding responsibility for oversight of Medicaid screening and treatment would be a natural extension of CDC's current leadership role in CLP prevention, but this requires an appropriate investment of additional federal resources. Finally, it is important to recognize that medical research is steadily accumulating convincing evidence that low blood lead levels are more harmful than previously recognized. This research only underscores the importance of protecting young children from lead exposure and reaffirms the need to complete the shift to primary prevention strategies.

---

[8] Alliance To End Childhood Lead Poisoning (now the Alliance for Healthy Homes), Track, Monitor, and Respond: Three Keys to Better Lead Screening for Children in Medicaid (Washington, DC: 2001) http://www.afhh.org/res/res_pubs/lead%20job%202.pdf.

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

APPENDICES

A. Number and Percentage of Medicaid-Enrolled Children Age 2 and Under Receiving EPSDT or Lead Screening in FY 1999 and FY 2003 by State

B. Trend Lines for Selected States: Lead Screening And EPSDT Screening Rates for Medicaid-Enrolled Children (FY 1999-FY 2003)

C. Percentage of Medicaid-Enrolled Children Receiving At Least One EPSDT Screen by State

D. Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test by State

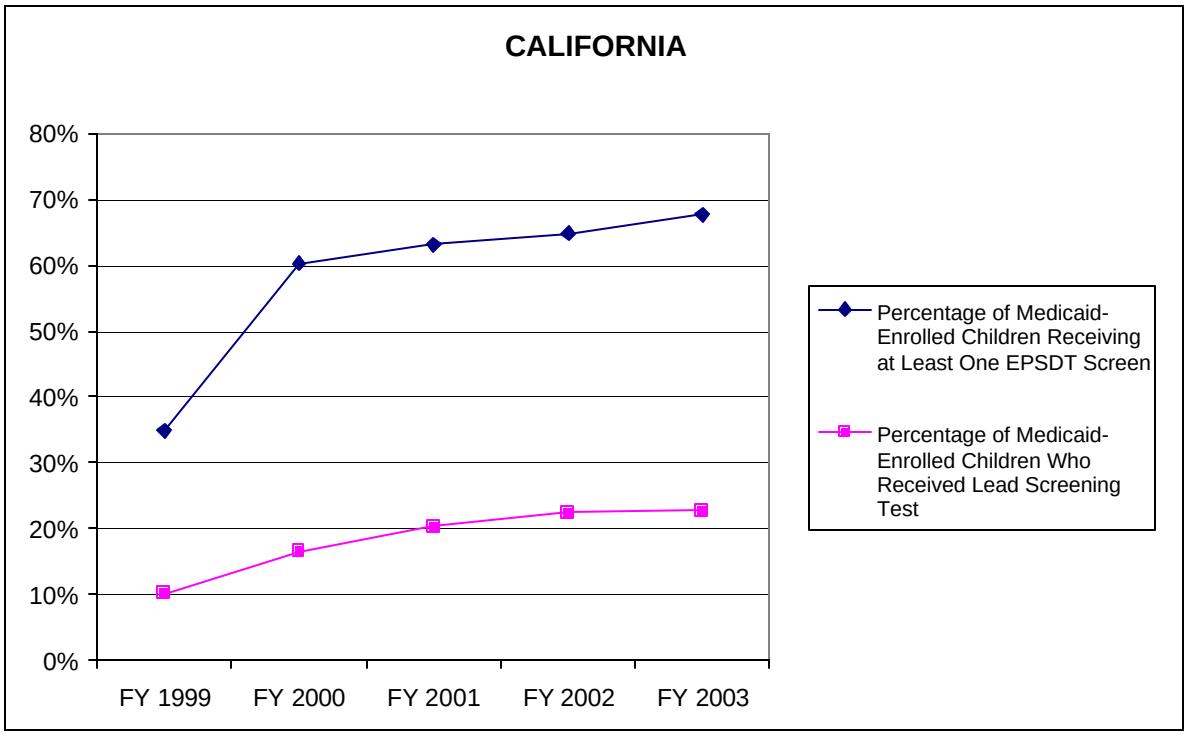
E. Percentage of Medicaid-Enrolled Children Receiving EPSDT Screens Who Received Lead Test by State

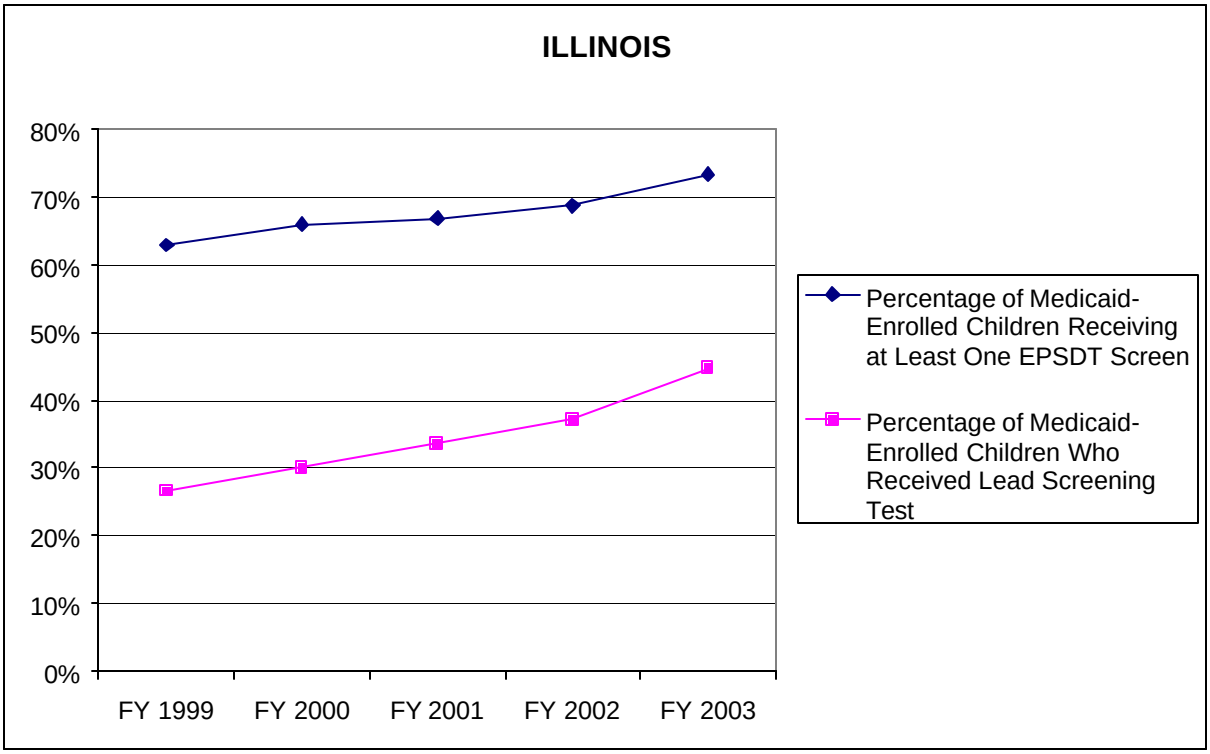
APPENDIX A—NUMBER AND PERCENT OF MEDICAID-ENROLLED CHILDREN AGE 2 AND UNDER RECEIVING EPSDT OR LEAD SCREENING IN FY 1999 AND FY 2003 BY STATE

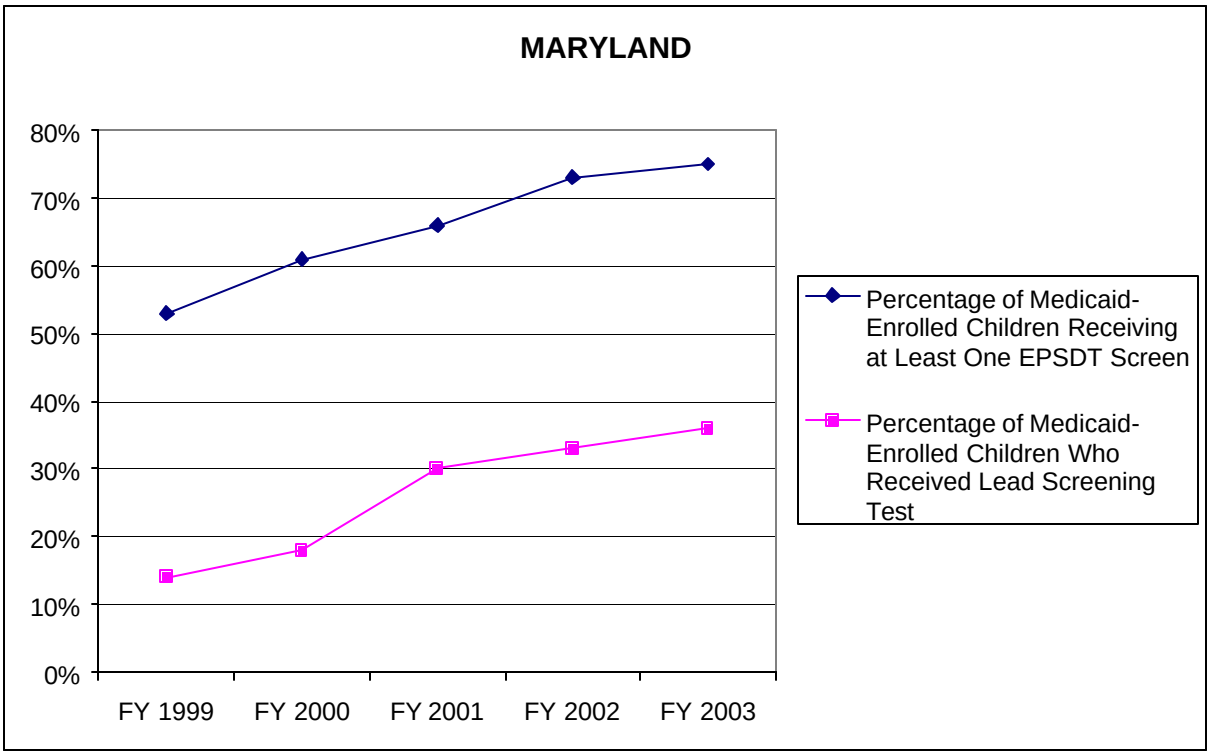
State	FY 1999			FY 2003		
	Total Eligible for EPSDT ≤2	Eligibles Receiving at least one EPSDT Screen ≤2	Eligibles Receiving Screening Blood Tests ≤2	Total Eligible for EPSDT ≤2	Eligibles Receiving at least one EPSDT Screen ≤2	Eligibles Receiving Screening Blood Tests ≤2
Alabama	95,348	67,891 71%	17,676 19%	104,597	90,879 87%	18,405 18%
Alaska	13,749	8,289 60%	3 0%	16,865	11,416 68%	4 0%
Arizona	75,249	57,424 76%	3,627 5%	138,867	100,325 72%	10,869 8%
Arkansas	65,051	27,581 42%	2,130 3%	88,989	38,800 44%	1,565 2%
California	741,825	300,724 41%	54,347 7%	729,736	537,302 74%	113,938 16%
Colorado	55,213	40,334 73%	177 0%	75,631	57,099 75%	4,505 6%
Connecticut	40,551	30,701 76%	2,628 6%	47,477	38,311 81%	3,049 6%
Delaware	13,185	6,784 51%	145 1%	16,213	11,518 71%	1,630 10%
District Of Columbia	16,676	7,272 44%	1,087 7%	15,298	11,063 72%	6,575 43%
Florida	275,585	182,978 66%	21,295 8%	388,236	295,818 76%	50,205 13%
Georgia	219,549	120,135 55%	7,998 4%	270,110	156,721 58%	17,313 6%
Hawaii	22,005	16,306 74%	2,900 13%			
Idaho				32,601	16,086 49%	340 1%
Illinois	200,388	143,261 71%	37,650 19%	244,952	196,151 80%	78,203 32%
Indiana	93,249	59,684 64%	2,194 2%	119,101	84,171 71%	7,954 7%
Iowa	37,631	30,367 81%	1,969 5%	46,827	40,123 86%	2,310 5%
Kansas	37,322	22,600 61%	4,949 13%	49,758	35,526 71%	11,309 23%
Kentucky	70,524	45,193 64%	3,943 6%	65,641	46,919 71%	10,448 16%
Louisiana	108,809	81,062 74%	20,674 19%	130,791	99,671 76%	33,331 25%
Maine						
Maryland	78,462	45,152 58%	7,495 10%	95,251	73,160 77%	23,351 25%
Massachusetts	90,920	46,024 51%	14,851 16%	91,829	90,464 99%	40,683 44%
Michigan	157,453	77,171 49%	19,574 12%	182,877	116,834 64%	35,098 19%

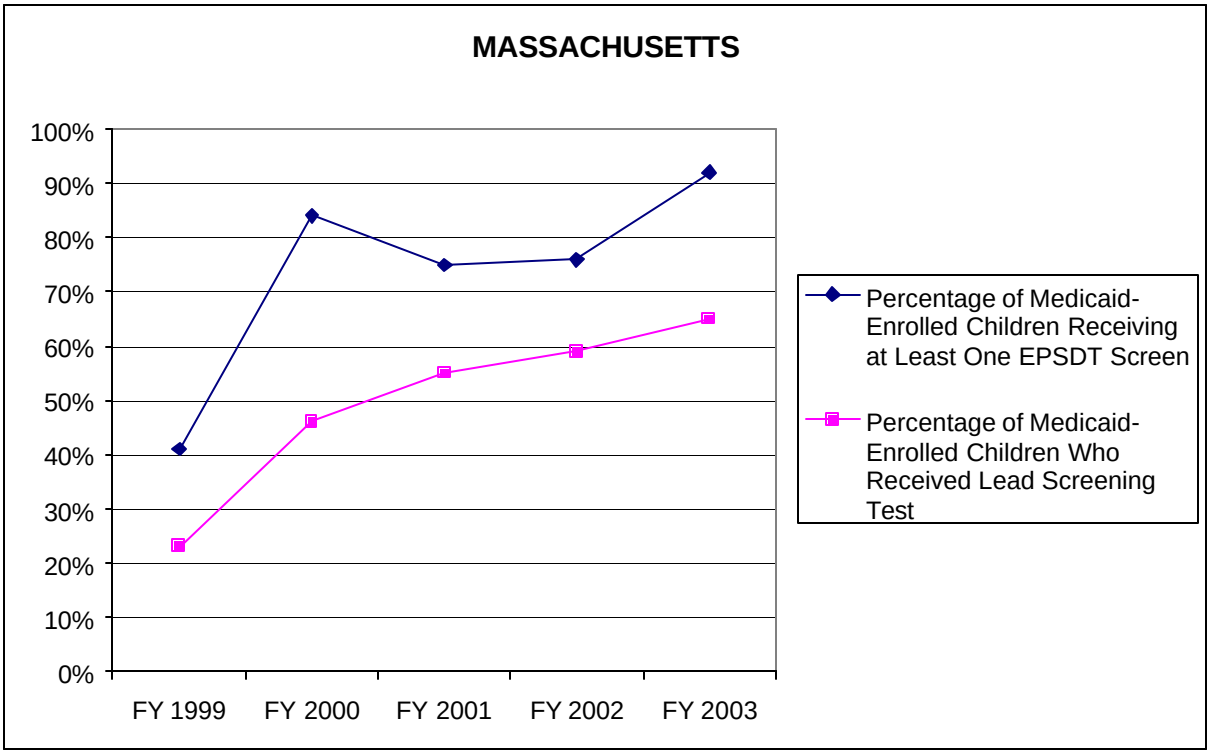
Minnesota	65,368	41,304 63%	7,977 12%	81,921	111,891 137%	22,091 27%
Mississippi	97,680	49,750 51%	5,494 6%	131,677	67,043 51%	29,946 23%
Missouri	102,535	56,791 55%	9,335 9%	119,566	92,771 78%	33,371 28%
Montana	11,421	7,050 62%	793 7%	14,352	10,261 71%	203 1%
Nebraska	23,964	19,879 83%	809 3%	35,960	29,171 81%	4,747 13%
Nevada				41,980	35,268 84%	439 1%
New Hampshire						
New Jersey	106,937	56,309 53%	11,251 11%	107,938	82,211 76%	35,843 33%
New Mexico	49,398	32,205 65%	757 2%			
New York	159,399			408,115	289,902 71%	0 0%
North Carolina	163,648	116,791 71%	26,302 16%	190,177	150,012 79%	32,794 17%
North Dakota	7,495	3,394 45%	297 4%	8,368	4,303 51%	643 8%
Ohio	167,347	95,905 57%	12,221 7%	211,518	164,155 78%	31,932 15%
Oklahoma	80,038	34,426 43%	856 1%			
Oregon	58,972	32,923 56%	1,003 2%	63,209	42,021 66%	2,211 3%
Pennsylvania	146,750	90,551 62%	46,914 32%	164,313	128,347 78%	102,907 63%
Rhode Island	15,779	12,977 82%	5,260 33%	18,965	15,168 80%	4,003 21%
South Carolina	93,803	52,954 56%	6,433 7%	110,055	64,261 58%	26,808 24%
South Dakota	11,873	6,981 59%	121 1%	16,271	11,510 71%	590 4%
Tennessee	158,015	58,142 37%	8,328 5%	136,135	91,961 68%	20,889 15%
Texas	797,730	457,049 57%	201,230 25%	658,415	516,399 78%	140,541 21%
Utah	45,633	32,713 72%	192 0%	59,197	39,199 66%	2,195 4%
Vermont	10,324	6,104 59%	165 2%	11,211	8,466 76%	59 1%
Virginia	92,755	59,748 64%	863 1%	129,910	81,129 62%	10,238 8%
Washington				120,233	83,240 69%	6 0%
West Virginia	44,404	31,943 72%	5,863 13%	40,920	32,908 80%	11,377 28%
Wisconsin	67,762	48,902 72%	2,978 4%	85,841	59,580 69%	25,063 29%
Wyoming	8,261	5,292 64%	602 7%	11,969	8,041 67%	0 0%

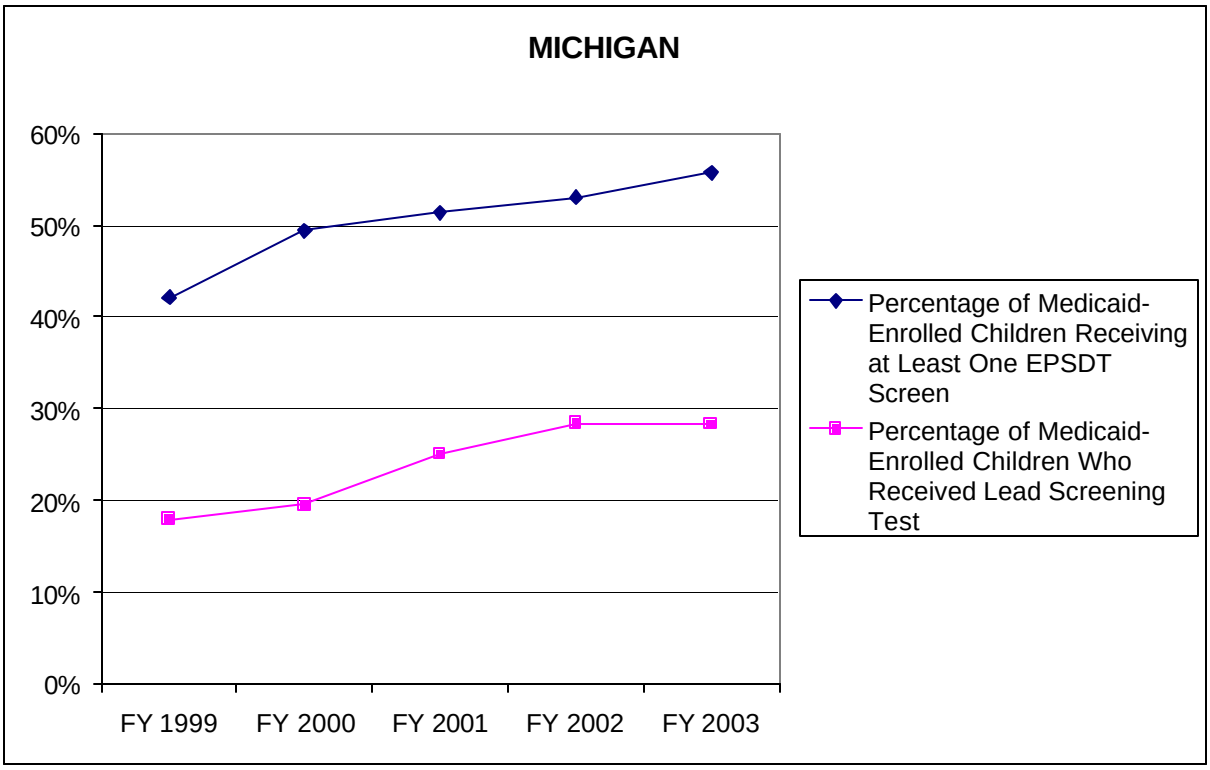
APPENDIX B—TREND LINES FOR SELECTED STATES: LEAD SCREENING AND EPSDT SCREENING RATES FOR MEDICAID-ENROLLED CHILDREN (FY 1999-FY 2003)

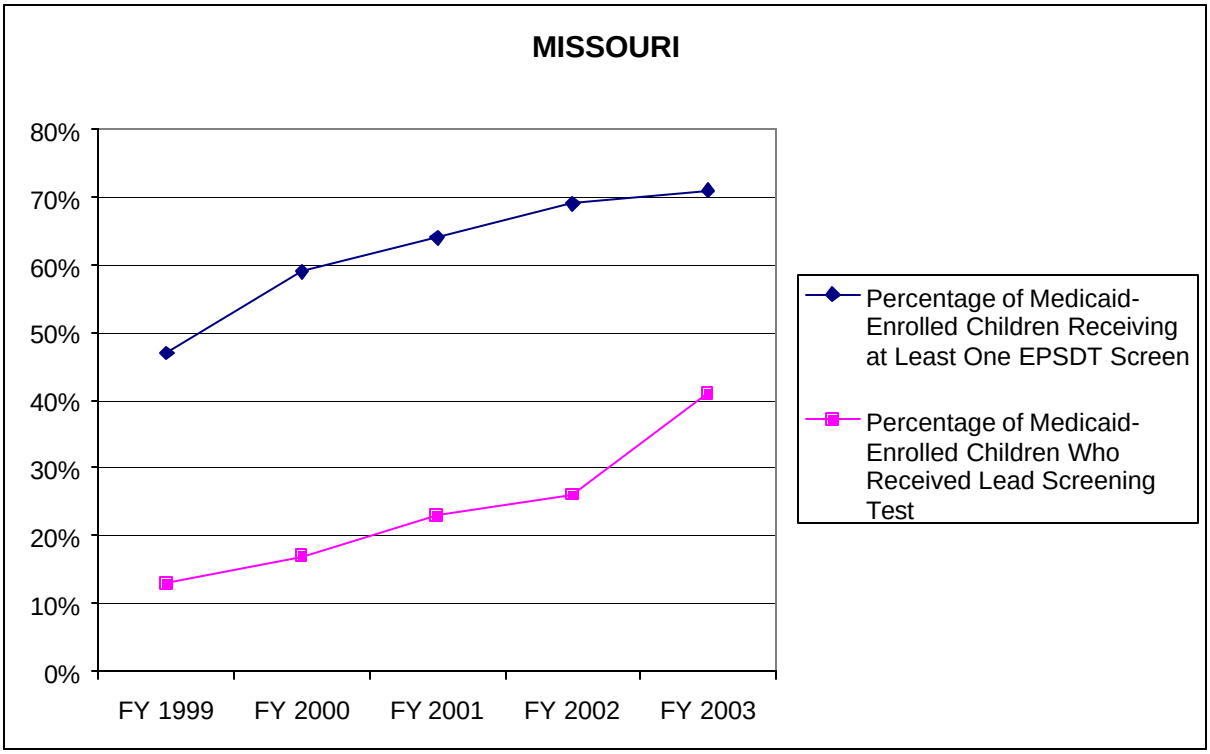


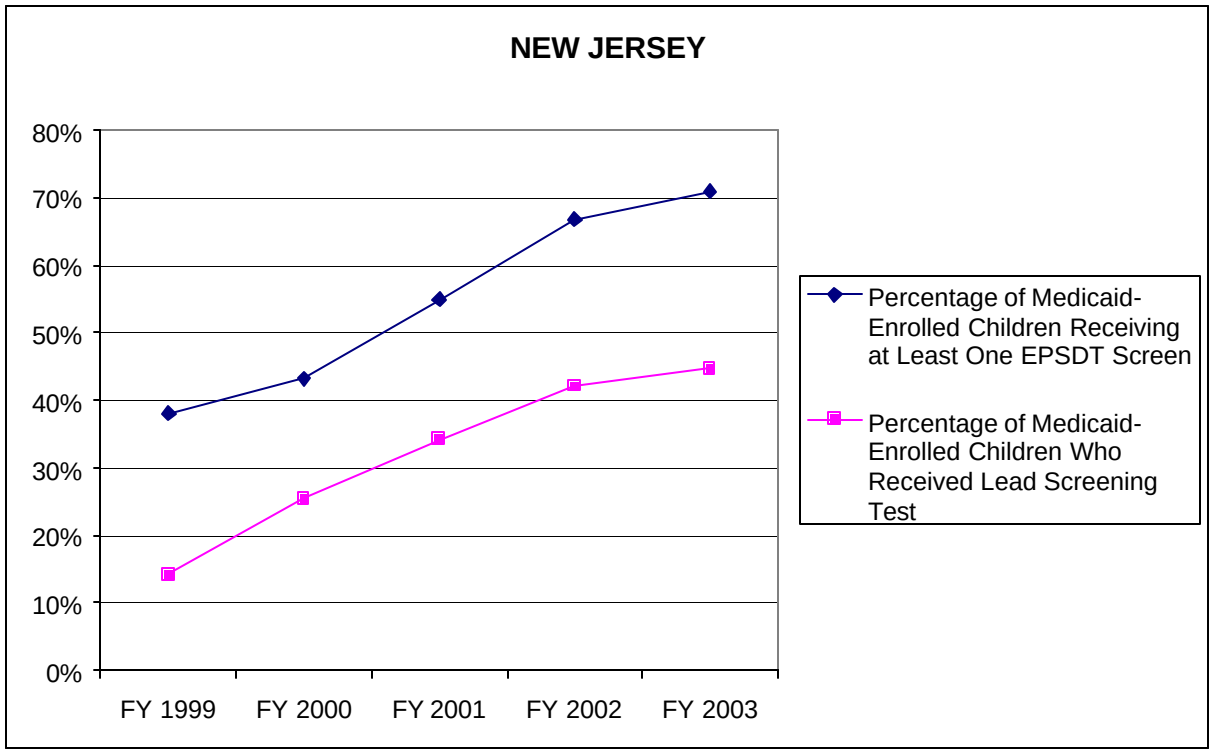


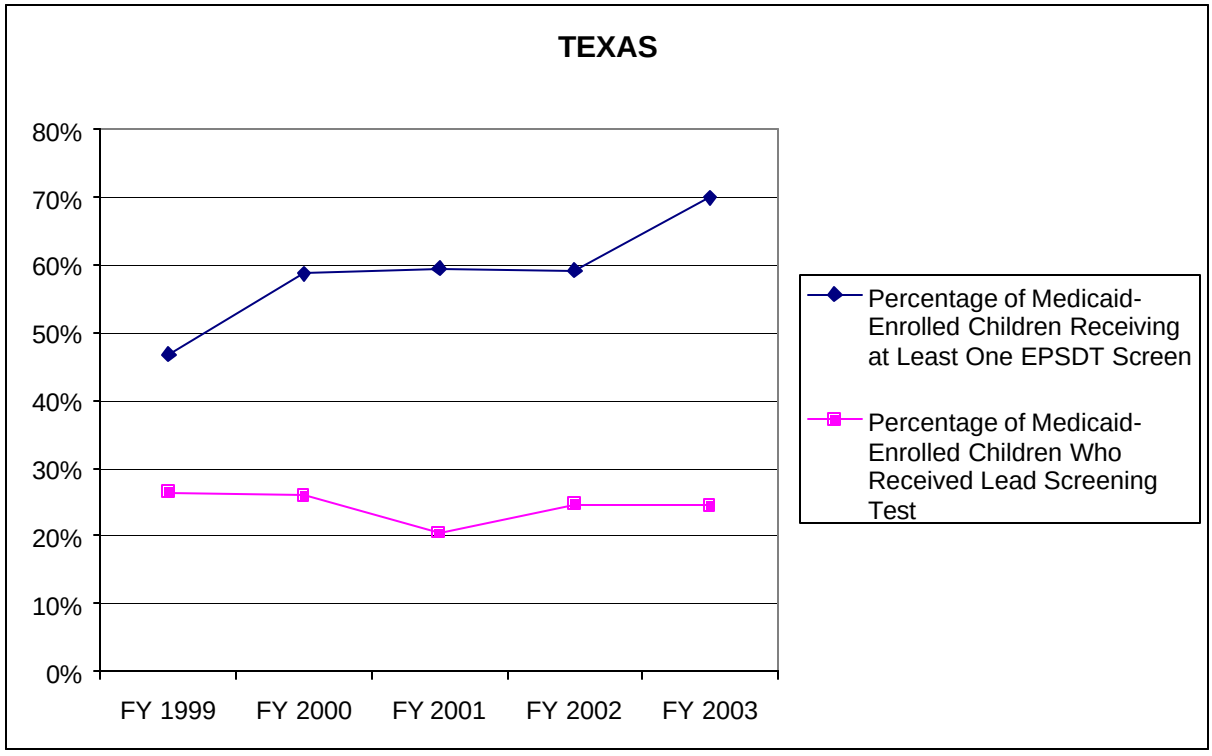

MARYLAND
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test


MASSACHUSETTS
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test


MICHIGAN
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test


MISSOURI
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test


NEW JERSEY
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test


TEXAS
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 1999
FY 2000
FY 2001
FY 2002
FY 2003
Percentage of Medicaid-Enrolled Children Receiving at Least One EPSDT Screen
Percentage of Medicaid-Enrolled Children Who Received Lead Screening Test

APPENDIX C—PERCENTAGE OF MEDICAID-ENROLLED CHILDREN RECEIVING AT LEAST ONE EPSDT SCREEN

	FY 1999			FY 2000			FY 2001			FY 2002			FY 2003		
State	**Age <1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age < 1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age < 1**	**Age 1-2**	**Age 3-5**
Alabama	115%	46%	42%	116%	54%	46%	126%	63%	53%	122%	67%	54%	125%	67%	54%
Alaska	76%	51%	50%	82%	57%	54%	82%	56%	52%	79%	53%	45%	83%	60%	51%
Arizona	85%	66%	51%	84%	57%	46%	88%	59%	45%	89%	66%	51%	84%	65%	48%
Arkansas	50%	31%	48%	49%	35%	48%	50%	33%	45%	51%	33%	45%	52%	35%	49%
California	48%	35%		74%	60%		73%	63%	42%	74%	65%	44%	86%	68%	50%
Colorado	89%	55%	31%				97%	64%	45%	108%	66%	49%	88%	68%	48%
Connecticut	80%	74%	63%	90%	78%	66%	74%	73%	64%				85%	79%	65%
Delaware	58%	48%	65%	51%	52%	61%	64%	59%	78%	56%	69%	69%	71%	71%	80%
District Of Columbia	35%	50%	39%	112%	51%	53%	81%	61%	65%	56%	52%	77%	73%	72%	79%
Florida	86%	55%	53%	85%	58%	51%	77%	62%	56%	81%	70%	62%	80%	74%	65%
Georgia	61%	51%	43%	65%	49%	41%	65%	45%	33%	70%	49%	34%	65%	54%	201%
Hawaii	83%	70%	68%	95%	77%	66%	84%	74%	72%	81%	64%	74%			
Idaho				54%	42%	100%	56%	45%	24%	45%	22%	10%	56%	46%	26%
Illinois	89%	63%	55%	92%	66%	60%	92%	67%	57%	93%	69%	61%	94%	73%	63%
Indiana	69%	61%	40%	72%	63%	41%	73%	65%	43%	73%	66%	44%	76%	68%	50%
Iowa	89%	76%	82%	90%	79%	88%	92%	82%	89%	74%	60%	55%	92%	82%	85%
Kansas	74%	53%	61%	82%	60%	65%	82%	62%	63%	82%	61%	61%	81%	67%	67%
Kentucky	79%	57%	41%				83%	60%	50%	87%	63%	58%	83%	65%	59%
Louisiana	88%	67%	50%	88%	64%	53%	87%	65%	51%	87%	67%	52%	88%	70%	57%
Maine				71%	84%	71%	72%	85%	72%	78%	82%	66%			
Maryland	67%	53%	48%	73%	61%	51%	77%	66%	55%	80%	72%	60%	81%	75%	62%
Massachusetts	70%	41%	52%	94%	84%	78%	87%	75%	69%	93%	76%	71%	112%	92%	84%
Michigan	63%	42%	41%	72%	49%	41%	73%	51%	40%	81%	53%	43%	80%	56%	42%
Minnesota	74%	58%	46%	76%	59%	48%	80%	64%	53%	84%	69%	57%	85%	162%	58%
Mississippi	60%	33%		63%	32%		63%	32%	30%	61%	31%	28%	59%	40%	36%
Missouri	72%	47%	36%	83%	59%	44%	87%	64%	49%	88%	69%	55%	90%	71%	56%
Montana	78%	44%	50%	78%	49%	36%	81%	53%	37%	84%	59%	46%	87%	63%	49%
Nebraska	108%	70%	60%	88%	70%	58%	93%	73%	57%	97%	74%	57%	97%	73%	57%
Nevada				47%	100%	79%	51%	98%	81%	54%	69%	89%	100%	70%	92%

New Hampshire				68%	47%		68%	55%	54%	72%	58%	59%			
New Jersey	82%	38%	34%	75%	43%	37%	80%	55%	47%	87%	67%	59%	88%	71%	59%
New Mexico	81%	57%	44%	77%	59%	43%	80%	60%	45%	82%	61%	46%			
New York				71%	69%	74%	72%	66%	73%	75%	71%	75%	75%	69%	74%
North Carolina	83%	64%	58%	87%	66%	59%	89%	69%	62%	90%	73%	65%	91%	73%	59%
North Dakota	59%	39%	46%	60%	39%	45%	55%	41%	54%	71%	37%	27%	68%	42%	46%
Ohio	67%	52%	44%				76%	62%	52%	82%	69%	56%	86%	73%	62%
Oklahoma	49%	40%	26%	46%	36%	23%	73%	43%	32%	53%	55%	40%			
Oregon	68%	70%	34%	79%	79%	41%	81%	56%	41%	80%	59%	43%	78%	60%	45%
Pennsylvania	65%	60%	47%	74%	66%	54%	78%	70%	59%	80%	72%	58%	86%	74%	63%
Rhode Island	79%	83%	86%				81%	75%	62%	85%	78%	65%	82%	79%	63%
South Carolina	60%	54%	28%	65%	58%	29%	65%	56%	28%	64%	58%	29%	65%	55%	28%
South Dakota	83%	45%	35%	84%	55%	46%	87%	60%	49%	83%	62%	46%	86%	63%	47%
Tennessee	54%	30%	34%	59%	36%	40%	60%	55%	48%	73%	58%	53%	76%	63%	58%
Texas	96%	47%		86%	59%	56%	77%	59%	52%	82%	59%	57%	93%	70%	59%
Utah	83%	59%	69%	84%	54%	60%	86%	50%	49%	81%	51%	48%	81%	51%	41%
Vermont	52%	63%	54%	56%	62%	52%	65%	89%	92%	67%	77%	90%	70%	78%	94%
Virginia	76%	57%	51%	77%	58%	52%	80%	60%	55%	78%	61%	56%	76%	45%	66%
Washington				38%	25%	18%	38%	36%	23%	30%	25%	18%	78%	66%	43%
West Virginia	135%	42%	35%	93%	66%	57%	91%	67%	57%	95%	75%	62%	91%	75%	62%
Wisconsin	94%	60%	40%	76%	54%	43%	77%	56%	45%	77%	60%	45%	81%	63%	48%
Wyoming	86%	52%	38%	85%	49%	37%	85%	52%	37%	87%	55%	37%	83%	58%	38%

(From Form 416: Line 9/Line 8)

Note: Some table values may exceed 100% due to reporting discrepancies and human error.

APPENDIX D — PERCENTAGE OF MEDICAID-ENROLLED CHILDREN WHO RECEIVED LEAD SCREENING TEST

	FY 1999			FY 2000			FY 2001			FY 2002			FY 2003		
State	**Age <1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**
Alabama	11%	23%	16%	5%	14%	11%	5%	14%	9%	8%	19%	11%	11%	21%	11%
Alaska	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Arizona	1%	9%	5%	2%	9%	5%	2%	8%	4%	2%	13%	7%	1%	12%	7%
Arkansas	1%	7%	2%	0%	3%	1%	0%	3%	1%	0%	1%	1%	1%	2%	1%
California	4%	10%	11%	1%	17%	10%	1%	20%	12%	1%	22%	11%	1%	23%	11%
Colorado	0%	0%	0%				1%	7%	3%	0%	7%	2%	1%	9%	3%
Connecticut	1%	9%	8%	7%	57%	44%	1%	10%	9%				0%	9%	7%
Delaware	0%	2%	2%	0%	9%	8%	0%	14%	17%	0%	8%	7%	0%	15%	7%
District Of Columbia	4%	9%	8%	12%	17%	18%	19%	28%	21%	3%	21%	35%	21%	53%	58%
Florida	2%	11%	11%	1%	11%	10%	2%	16%	13%	2%	18%	13%	2%	20%	14%
Georgia	1%	5%	4%	1%	5%	2%	1%	4%	2%	2%	5%	2%	2%	9%	17%
Hawaii	6%	16%	4%	11%	16%	4%	6%	26%	7%	5%	23%	6%			
Idaho				0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	2%	1%
Illinois	3%	27%	31%	5%	30%	33%	4%	34%	33%	5%	37%	36%	6%	45%	39%
Indiana	0%	3%	3%	0%	6%	6%	0%	8%	6%	0%	12%	9%	1%	10%	7%
Iowa	1%	8%	7%	1%	8%	7%	1%	12%	10%	1%	8%	6%	0%	7%	5%
Kansas	2%	20%	17%	2%	22%	15%	1%	22%	16%	1%	23%	18%	3%	33%	23%
Kentucky	1%	8%	5%				2%	21%	11%	2%	19%	10%	2%	24%	13%
Louisiana	2%	28%	19%	2%	21%	14%	1%	21%	12%	1%	22%	13%	2%	37%	22%
Maine				3%	18%	11%	2%	21%	10%	3%	25%	11%			
Maryland	1%	14%	10%	2%	18%	11%	2%	30%	18%	2%	33%	19%	2%	36%	22%
Massachusetts	3%	23%	31%	5%	46%	44%	5%	55%	50%	5%	59%	51%	5%	65%	57%
Michigan	1%	18%	26%	2%	20%	29%	2%	25%	29%	2%	28%	33%	1%	28%	31%
Minnesota	2%	17%	17%	2%	19%	14%	2%	23%	17%	2%	31%	19%	3%	39%	21%
Mississippi	4%	8%	1%	3%	5%	6%	7%	14%	18%	8%	9%	10%	17%	32%	29%
Missouri	1%	13%	10%	1%	17%	11%	1%	23%	14%	2%	26%	16%	2%	41%	0%
Montana	3%	11%	6%	0%	0%	0%	0%	5%	2%	0%	2%	1%	0%	2%	2%
Nebraska	1%	5%	4%	1%	16%	13%	1%	19%	13%	1%	21%	15%	1%	19%	11%
Nevada				0%	4%	3%	0%	2%	2%	0%	2%	2%	0%	2%	2%

New Hampshire				3%	27%	10%	1%	25%	9%	2%	32%	8%			
New Jersey	3%	14%	15%	2%	25%	25%	6%	34%	31%	7%	42%	37%	8%	45%	37%
New Mexico	0%	2%	1%	0%	2%	1%	0%	2%	1%	0%	3%	1%			
New York				3%	29%	34%									
North Carolina	1%	25%	14%	1%	27%	14%	1%	29%	14%	1%	32%	13%	1%	26%	9%
North Dakota	3%	4%	3%	3%	7%	5%	4%	8%	7%	0%	11%	7%	1%	11%	5%
Ohio	1%	10%	11%				1%	14%	12%	1%	18%	13%	1%	22%	15%
Oklahoma	1%	1%	1%	2%	2%	1%	0%	3%	1%	0%	7%	3%			
Oregon	0%	3%	1%	0%	4%	2%	0%	4%	2%	1%	5%	3%	0%	5%	3%
Pennsylvania	7%	43%	25%	5%	34%	22%	17%	49%	27%	31%	60%	24%	47%	70%	25%
Rhode Island	4%	47%	42%				0%	0%	0%	3%	30%	26%	3%	30%	25%
South Carolina	1%	10%	4%	1%	22%	7%	2%	25%	5%	1%	14%	4%	2%	35%	8%
South Dakota	0%	2%	0%	0%	2%	1%	0%	4%	2%	0%	5%	3%	0%	5%	3%
Tennessee	8%	4%	6%	9%	4%	4%	1%	9%	5%	2%	19%	14%	2%	22%	15%
Texas	23%	26%		22%	26%	26%	16%	20%	19%	19%	25%	20%	16%	24%	16%
Utah	0%	0%	0%	1%	1%	0%	1%	1%	0%	1%	2%	1%	2%	6%	2%
Vermont	0%	2%	1%	0%	2%	1%	0%	2%	1%	0%	1%	0%	0%	1%	0%
Virginia	0%	1%	1%	0%	1%	1%	0%	1%	1%	1%	2%	2%	7%	9%	10%
Washington				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
West Virginia	15%	13%	6%	15%	22%	11%	11%	21%	11%	15%	29%	18%	16%	34%	18%
Wisconsin	1%	6%	6%	4%	46%	32%	4%	53%	36%	4%	58%	34%	3%	42%	22%
Wyoming	1%	11%	7%	9%	7%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%

(From Form 416: Line 14/Line 8)

APPENDIX E— PERCENTAGE OF MEDICAID-ENROLLED CHILDREN RECEIVING EPSDT SCREENS WHO RECEIVED LEAD TEST BY STATE

	FY 1999			FY 2000			FY 2001			FY 2002			FY 2003		
State	**Age < 1**	**Age 1-2**	**Age 3-5**	**Age < 1**	**Age 1-2**	**Age 3-5**	**Age < 1**	**Age 1-2**	**Age 3-5**	**Age <1**	**Age 1-2**	**Age 3-5**	**Age < 1**	**Age 1-2**	**Age 3-5**
Alabama	9%	50%	39%	5%	26%	23%	4%	22%	18%	6%	29%	20%	9%	32%	19%
Alaska	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Arizona	1%	13%	11%	2%	16%	12%	2%	14%	10%	2%	19%	14%	1%	18%	14%
Arkansas	1%	24%	5%	0%	10%	3%	1%	10%	3%	0%	3%	2%	2%	7%	3%
California	8%	29%	24%	1%	27%	26%	1%	32%	28%	1%	34%	26%	1%	34%	23%
Colorado	0%	1%	0%				1%	11%	6%	0%	10%	5%	1%	14%	7%
Connecticut	1%	13%	13%	8%	73%	66%	1%	14%	14%				0%	12%	11%
Delaware	0%	3%	2%	1%	17%	14%	0%	24%	21%	0%	11%	10%	0%	21%	9%
District Of Columbia	11%	17%	21%	11%	34%	33%	23%	46%	32%	6%	41%	45%	29%	74%	73%
Florida	2%	21%	21%	1%	19%	19%	3%	26%	23%	2%	26%	22%	3%	27%	21%
Georgia	1%	11%	9%	1%	10%	6%	1%	9%	5%	3%	10%	6%	4%	16%	8%
Hawaii	8%	23%	6%	11%	21%	6%	8%	34%	10%	7%	36%	8%			
Idaho				0%	1%	0%	0%	1%	0%	0%	2%	2%	0%	3%	3%
Illinois	4%	42%	56%	5%	46%	55%	5%	50%	58%	5%	54%	59%	6%	61%	61%
Indiana	1%	6%	7%	0%	10%	14%	1%	12%	15%	1%	18%	21%	1%	14%	14%
Iowa	1%	10%	8%	1%	10%	7%	1%	15%	11%	1%	14%	11%	0%	9%	6%
Kansas	2%	38%	28%	2%	37%	24%	2%	36%	25%	2%	37%	30%	3%	50%	35%
Kentucky	1%	14%	11%				3%	34%	22%	2%	30%	17%	3%	36%	23%
Louisiana	2%	42%	38%	2%	33%	27%	2%	32%	23%	1%	33%	25%	2%	53%	39%
Maine				4%	22%	15%	3%	24%	14%	3%	30%	17%			
Maryland	2%	26%	21%	3%	29%	22%	3%	45%	34%	3%	45%	31%	3%	48%	36%
Massachusetts	4%	57%	61%	5%	55%	56%	5%	73%	72%	5%	78%	72%	5%	71%	68%
Michigan	2%	43%	64%	2%	40%	70%	3%	49%	71%	2%	54%	76%	2%	51%	73%
Minnesota	2%	30%	37%	2%	32%	30%	3%	36%	31%	3%	44%	33%	3%	24%	36%
Mississippi	7%	25%	28%	5%	14%	20%	11%	43%	60%	13%	28%	34%	28%	80%	81%
Missouri	1%	29%	27%	2%	30%	25%	2%	36%	28%	2%	37%	29%	2%	57%	0%
Montana	3%	26%	12%	0%	0%	0%	0%	9%	6%	0%	4%	2%	0%	3%	4%
Nebraska	1%	7%	6%	1%	23%	22%	1%	26%	23%	1%	29%	25%	1%	27%	20%

Nevada				0%	4%	4%	0%	2%	2%	0%	3%	2%	0%	3%	2%
New Hampshire*				4%	58%	22%	2%	46%	16%	3%	54%	14%			
New Jersey	4%	37%	44%	3%	59%	68%	7%	62%	66%	8%	63%	64%	9%	63%	63%
New Mexico	0%	4%	3%	0%	3%	2%	0%	3%	2%	0%	5%	3%			
New York				4%	42%	46%									
North Carolina	1%	39%	23%	1%	41%	23%	1%	41%	22%	1%	44%	20%	1%	36%	16%
North Dakot a	5%	12%	7%	6%	18%	11%	7%	19%	13%	1%	29%	27%	1%	27%	11%
Ohio	2%	20%	26%				1%	23%	24%	1%	26%	24%	1%	30%	24%
Oklahoma	3%	2%	2%	4%	4%	3%	0%	7%	2%	1%	14%	6%			
Oregon	0%	5%	4%	0%	5%	4%	0%	7%	6%	1%	8%	7%	0%	8%	7%
Pennsylvania	11%	72%	53%	7%	51%	41%	22%	70%	46%	39%	84%	42%	54%	94%	40%
Rhode Island	5%	56%	48%				0%	0%	0%	3%	39%	40%	4%	38%	39%
South Carolina	1%	19%	13%	1%	39%	23%	4%	45%	19%	1%	24%	13%	3%	63%	28%
South Dakota	0%	300%	1%	0%	4%	1%	0%	6%	4%	0%	7%	7%	0%	8%	5%
Tennessee	15%	14%	19%	15%	10%	11%	1%	17%	11%	2%	33%	26%	2%	35%	26%
Texas	24%	56%		25%	44%	46%	20%	34%	36%	23%	42%	36%	17%	35%	27%
Utah	1%	1%	0%	1%	1%	1%	1%	3%	1%	1%	5%	2%	2%	11%	6%
Vermont	0%	4%	2%	0%	3%	1%	0%	2%	1%	0%	2%	0%	0%	1%	0%
Virginia	0%	2%	2%	0%	2%	2%	0%	3%	2%	1%	4%	4%	9%	19%	15%
Washington				0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
West Virginia	11%	30%	17%	16%	33%	20%	12%	32%	19%	16%	39%	29%	18%	45%	30%
Wisconsin	1%	11%	15%	5%	85%	75%	5%	94%	79%	5%	97%	75%	4%	67%	45%
Wyoming	2%	20%	19%	10%	14%	18%	0%	0%	0%	0%	0%	0%	0%	0%	0%

(From Form 416: Line 14/Line 9)

ALLIANCE FOR HEALTHY HOMES
Protecting Children from Lead and Other Environmental Health Hazards

227 Massachusetts Avenue, NE
Suite 200
Washington, DC 20002
202-543-1147
FAX 202-543-4466
afhh@afhh.org
www.afhh.org