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TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed

SUBJECT: **PROCLAMATION OF "LEAD POISONING PREVENTION WEEK" IN LOS ANGELES COUNTY: ENSURING RESIDENTS ARE LEAD-AWARE (ITEM 2, BOARD AGENDA OF SEPTEMBER 24, 2024, DIRECTIVE 8)**

On September 24, 2024, your Board passed a motion that directed, in part, the Department of Public Health (Public Health) to collaborate with County Counsel to provide a written report to the Board in 90 days regarding the feasibility of including a requirement in Memoranda of Understanding and contracts with external medical providers that mandates that providers customarily screen young children for lead exposure, and provide education about lead exposure to their patients.

After discussions between Public Health and County Counsel, there was strong agreement that because lead screening rates for young children at risk of lead poisoning are alarmingly low in Los Angeles County (County) and the state of California, efforts to increase these screening rates are necessary. However, there was also strong agreement that including a requirement in Memoranda of Understanding (MOUs) and contracts with external medical providers that mandates lead screening for their young patients is not likely to be effective in achieving the indicated goal of improving lead screening rates in the County.

This is because the state of California and its Medicaid program have already enacted requirements for health care providers to carry out lead screenings in alignment with best practice clinical guidelines, as well as current legislation on the topic. This report will illustrate the scope of the current problem regarding inadequate lead screening rates for young children at risk of lead exposure and toxicity, explain why requiring MOUs and contracts may not be practical or effective

in achieving the goal of increasing screening rates, and present alternative strategies for your Board to consider in improving lead screening rates in the County.

Current Screening Guidelines for Prevention of Child Lead Poisoning

According to the United States Centers for Disease Control and Prevention (CDC), all children ***at risk*** for lead exposure should be tested for lead poisoning. Children more likely to be exposed, and therefore at risk for lead exposure include those who:

- Live or spend time in a house or building built before 1978.
- Are from low-income households.
- Are immigrants, refugees, or recently adopted from less developed countries.
- Live or spend time with someone who works with lead.
- Live or spend time with someone who has hobbies that expose them to lead.[1]

In addition, the CDC recommends that parents talk to their child's healthcare provider about whether their child needs to be tested for lead. The healthcare provider may ask questions, including but not limited to those indicated above, to assess if the child is at risk for lead poisoning.

In alignment with the above guidance, all children enrolled in Medicaid, (called Medi-Cal in California), are required to get tested for lead at 12 months and 24 months of age. They must also be tested if they are between 24 and 72 months old and have no prior record of testing.[2] Medi-Cal health plans monitor their network providers' performance on lead screening quality measures; health plans in turn are monitored on this measure by the California Department of Health Care Services (DHCS). For children not enrolled in Medicaid, CDC recommends focusing testing efforts on high-risk neighborhoods and populations. Although enrollment in Medicaid may not capture every child at increased risk of lead exposure, eligibility is largely based on family income and includes primarily lower income families; thus, it is a strong proxy for lead exposure risk and correlates well with the population of children at higher risk.

The state of California already has statutes in place that meet and exceed the minimal Federal standards aimed at preventing child lead poisoning.[3] By statute, healthcare providers who perform periodic health assessments on children are assigned certain responsibilities with respect to prevention of child lead poisoning. Providers are required to share anticipatory guidance at every periodic health assessment between 6 months and 6 years of age. That guidance includes informing parents about: the risks and effects of childhood lead exposure, the requirement that all

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[1] Testing for Lead Poisoning in Children. https://www.cdc.gov/lead-prevention/testing/index.html#:~:text=The%20best%20way%20to%20know,record%20of%20ever%20being%20tested. Accessed January 27, 2025.

[2] https://www.cdc.gov/lead-prevention/testing/index.html. Accessed February 5, 2025.

[3] California Health and Safety Code, Sections 105275-105310. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=103.&title=&part=5.&chapter=5.&article= Accessed January 27, 2025.

children enrolled in Medi-Cal should be tested for lead exposure, and the requirement that all children not in Medi-Cal but at increased risk for lead exposure should also be tested.

Further responsibilities for California healthcare providers include screening all children at 12 and 24 months of age who are enrolled in publicly funded programs for low-income children such as Medi-Cal and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) via blood lead testing.[4] This is more inclusive than current federal regulations, which do not have a lead screening requirement for programs other than Medicaid. Furthermore, Medi-Cal expansion efforts in recent years have increased eligibility in California for many people who are not necessarily Medicaid-eligible in other states. For example, all eligible children regardless of immigration status may be enrolled in Medi-Cal.

Children not enrolled in a publicly funded program for low-income families must be assessed for risk at 12 and 24 months by asking: "Does your child live in or spend a lot of time in a place built before 1978 that has peeling or chipped paint, or that has been recently remodeled?"[5] A blood lead test should be performed if the answer is, "yes," or "don't know". There are also catch-up mandates if the 12- and 24-months milestones are missed, extending up through 72 months of age.

Guidance from the Child Lead Poisoning Prevention Branch of the California Department of Public Health (CDPH) also recommends other risk factors for consideration and assessment by healthcare providers that may indicate need for a blood lead test, although they are not mandated in the state regulations. These include: any suspected lead exposure, parental request, and recent immigration from a country with high levels of environmental lead.[6]

Mandatory Screening of Blood Lead Levels for All Children Enrolled in Medi-Cal: What Does Recent Data Indicate?

Unfortunately, despite requirements for periodic lead exposure screening of all children enrolled in Medi-Cal, actual screening rates remain disappointing. Note that for all the statistics that follow in this section, the goal is 100%. In 2022, the most recent year for which comprehensive statewide and countywide data is available, the average rate of blood lead testing at 12 months of age for children enrolled in Medi-Cal was approximately 48% statewide, with significant variation among different races and ethnicities; no demographic group had a screening rate above 58%.[7] Los Angeles County Medi-Cal lead testing rates for the same year fell in the range of 41% to 50%, similar to statewide results.[8]

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[4] California Code of Regulations, Title 17, §§ 37000-37100.

[5] California Health and Safety Code Section 105285

[6] Standard of Care on Screening for Childhood Lead Poisoning, at https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx accessed January 31, 2025.

[7] 2023 Preventive Services Report. California Department of Health Care Services Quality and Population Health Management. April 2024, at https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2022-23-Preventive-Services-Report.pdf accessed February 3, 2025.

[8] California's Progress in Preventing and Managing Childhood Lead Exposure. California Department of Public Health Childhood Lead Poisoning Prevention Branch. At https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CLPPBReport2024.pdf accessed February 3, 2025.

The average rate of blood lead testing at 24 months of age for children enrolled in Medi-Cal was approximately 39% statewide in 2022, with no demographic group exceeding 44%. For Los Angeles County, the same statistic in 2022 was in the range of 40% to 48%, comparable to statewide results.[9]

The percentage of children in Medi-Cal who had received two blood lead tests by age 24 months was approximately 23% statewide in program year 2022.[10] No demographic group had a result higher than 29%. Los Angeles County in comparison had a rate for the same measure in the range of 22% to 33%, largely overlapping with statewide data.

One might consider whether the significant social upheaval that began in 2020 with the onset of the COVID-19 pandemic was still impacting clinical visits for periodic child health assessments in 2022. Data analyzed from years preceding the pandemic discount this theory. A report from the California State Auditor analyzed Medi-Cal data including fiscal years 2009-10 through 2017-18, concluding that nearly half (1.4 million children) of those required to be tested under state regulations did not receive a test, while another quarter of those children received a test at 12 months or 24 months but not both, as required.[11] The 2022 data does not differ substantively from that of the prior decade before the pandemic.

However, an additional study of note suggests that the actual blood lead level screening rates for children on Medi-Cal may be significantly higher than what the above data indicates. Because children may be enrolled in and later disenroll from Medi-Cal at different periods in their lives, data maintained by DHCS (which administers the Medi-Cal program) may be incomplete and have limitations in accurately determining screening rates. A collaborative study was undertaken by CDPH, which is responsible for statewide child lead poisoning prevention activities and maintains its own database of child lead testing, and DHCS. It was thought that combining efforts and comparing databases could provide more accurate information about how many children on Medi-Cal had received required testing. A study of children who turned three during Federal Fiscal Year 2016 found that among those who had ever been enrolled in Medi-Cal within their first three years of life, 65% had received at least one blood lead test. For those 3-year-olds who had been enrolled in Medi-Cal continuously from age 6 months through age 3 years, 73% had been screened at least once.[12] Although these calculated rates are significantly higher than the rates obtained from DHCS data alone, an additional conclusion that is unavoidable is this: even with differing methodology to improve accuracy of calculations and reveal that lead testing rates may be higher than initially thought, these results still fall far below the goal of 100% screening for children at increased risk of lead exposure.

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[9] Ibid.

[10] 2023 Preventive Services Report. https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2022-23-Preventive-Services-Report.pdf

[11] Childhood Lead Levels: Millions of Children in Medi-Cal Have Not Received Required Testing for Lead Poisoning. *Report 2019-105.* California State Auditor. January 2020. at https://information.auditor.ca.gov/pdfs/reports/2019-105.pdf accessed February 3, 2025.

[12] Blood Lead Screening Rates for a Cohort of California Children Served by Medi-Cal: A Joint Report from the California Department of Public Health-Department of Health Care Services, at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/CDPH-DHCS_Cohort_Analysis.pdf accessed February 3, 2025.

The above review of standards for child lead poisoning prevention/screening and relevant data on blood lead level screening rates for children enrolled in Medi-Cal points to several conclusions that will be critical in considering the question posed at the outset of this report: whether all County MOU and contracts with external medical providers should require blood lead testing and education about lead exposure for their patients. Relevant conclusions:

- Current evidence-based screening guidelines for blood lead testing recommend testing children at risk for lead exposure, rather than all children universally.
- California already has existing comprehensive law mandating healthcare providers to screen all young children at risk for lead exposure.
- Testing that screens for lead exposure is automatically required due to a child's enrollment in Medi-Cal or another program serving low-income children. Recent expansions of Medi-Cal to include all eligible children makes the program a good (albeit imperfect) proxy to denote increased risk of lead of exposure. Children not enrolled in such programs must still be assessed for risk at appropriate ages and tested, if indicated.
- Despite these mandates, screening rates for children on Medi-Cal fall far short of the 100% goal and have significant room for improvement.
- Screening rates for Los Angeles County children in Medi-Cal closely align with statewide Medi-Cal screening rates.

Should Los Angeles County Require Blood Lead Testing and Education in All MOU and Contracts with External Medi-Cal Providers?

After deliberation between Public Health and County Counsel, we do not recommend pursuing such a strategy at this time. This strategy may be difficult and costly to implement, and there are additional concerns about its effectiveness in increasing lead screening rates. The key reasons for its infeasibility are outlined below.

Redundancy

All County contracts include standard language to the effect that the contractor must abide with all applicable federal, state, and local laws and regulations. Therefore, by extension, all medical providers that enter formal MOUs and contracts with the County are already under notice from the County that they must comply with child lead screening and education regulations, although lead screening *per se* may not be specifically mentioned in the agreement.

Reach and Scope

It was observed that County MOUs and contracts with external medical providers may be few in number, and/or generally not inclusive of providers who serve significant numbers of young children receiving periodic health assessments. For example, within Public Health, formal MOUs and contracts with external medical providers comprise a very small fraction of all MOUs and contracts executed by the department. The Division of Human Immunodeficiency Virus and Sexually Transmitted Diseases Prevention (DHSP), a Public Health division that maintains formal relationships with external medical providers, has such arrangements with specialty medical providers who may not do periodic health assessments on a significant number of young children.

In other words, a strategy that has all County MOUs and contracts with external medical providers require customary testing of children for lead exposure would subsequently impact a relatively small percentage of children in the County who are currently missing such screening.

Furthermore, any requirements by the County to require testing of children should align with current evidence-based screening guidelines for identification of lead exposure and toxicity. As outlined above, current guidelines and standards of care recommend testing ***at risk*** children rather than testing all children universally, and these are the standards reflected in current state law. Dictating additional preventive and screening requirements that lack scientific support and do not align with expert guidance could undermine trust and collaboration between the County and external medical providers. Such well-functioning relationships are critical to the overall health of Los Angeles County residents.

The above point raises a valid question: if requirements for blood lead testing were expanded to include all children at appropriate ages, rather than only those in public programs for low-income children or those assessed to be at increased risk, wouldn't that by extension capture many of the children who *are* at risk and currently missing out on screening? Fortunately, this very question has been examined in the state of California several years ago.

During the 2017-2018 legislative session, Assembly Bill No.1316 was introduced that would have had the effect of requiring blood lead testing for all children at certain ages.[13] As part of the analysis of effectiveness of this bill to identify more lead-exposed children, a modeling study was performed by the California Health Benefits Review Program.[14] The results of this study suggested that a universal screening mandate in California would more than triple the number of children screened, with a concomitant increase in health care costs and a corresponding significant increase in the risk of false positive results. It was estimated that this effort would identify an additional 4,777 exposed children statewide. The report of the state Auditor that occurred during an overlapping time period identified approximately 1.4 million children enrolled in Medi-Cal who were not tested. The authors concluded that, "the evidence for a net societal benefit of universal screening approach is limited and is not supported by prominent medical professional groups." Ultimately, an amended version of AB 1316 was adopted and chaptered to expand targeted screening to identify additional children at higher risk for lead poisoning on the basis of California-specific risk factors, reflected in current statute discussed earlier in this report.

Notwithstanding the information relayed above, none of the conclusions indicated are applicable to the anticipatory guidance and lead poisoning education that *is* required for all children and is currently provided for by CDPH through Child Lead Poisoning Prevention grants with all local health jurisdictions in the state, including Los Angeles County Public Health.

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[13] AB-1316 Public health: childhood lead poisoning: prevention. At https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB1316 accessed February 4, 2025.

[14] Universal Lead Screening Requirement: A California Case Study. McMenamin, SB, et al. *Am J Public Health.* 2018 Mar;108(3):355–357. doi: https://doi.org/10.2105/AJPH.2017.304239 Accessed at https://pmc.ncbi.nlm.nih.gov/articles/PMC5803804/ February 4, 2025.

Assurance Challenges

Were the County to include such specific requirements in all MOU and contracts with external medical providers, several practical challenges arise, mostly related to assuring compliance with the added requirements.

To determine if these external medical providers were in compliance with this requirement, specialized audits including extensive chart review would be required. The audit would need to determine: (1) if every child is receiving required education and anticipatory guidance, (2) if every child who is enrolled in Medi-Cal has received required blood lead testing, and, (3) if every child not enrolled in Medi-Cal has received required assessment of risk and has received required blood lead testing if indicated by the risk assessment. Whether this complex evaluation would be performed by County staff or by an external auditor under contract, the cost to the County would be great and is unlikely to be reimbursed by any current funding source, thus the activities would add to net County costs.

Furthermore, were the County to perform the activities described above, assuring corrective action and ongoing compliance creates additional practical challenges. Essentially, the County's response to an external entity that is not in compliance with the requirements of an MOU or contract and does not demonstrate corrective actions to come into compliance, is to withhold payment and ultimately to terminate the arrangement. Moreover, the reason such MOU or contracts exist with external medical providers is to provide services to the community that are considered critical and/or essential to the health and safety of County residents. To potentially interrupt such critical services to ensure a supplemental and secondary purpose could end up being counterproductive and costly to both the County as well as to the residents we are committed to serving.

Other Opportunities

If including language in County MOUs and contracts with external medical providers to require customary lead testing of children is not particularly feasible or likely to be effective in identifying additional children exposed to lead, there are additional promising strategies that may be adopted that could affect the change we would like to see. The next and final section of this report will offer some recommendations that may help to address this problem and demonstrate improvement in blood lead testing rates.

Recommendations to Improve Rates of Child Lead Testing and Lead Exposure Education

Lead exposure education is required for all children at all periodic health assessments from ages 6 months to 6 years.[15] Public Health receives a Child Lead Poisoning Prevention grant from CDPH to conduct various lead poisoning prevention activities, including community education for both residents and healthcare providers, distributing state-approved patient education materials for County medical providers, and offering clinical guidance resources for use by the providers themselves. Public Health has established long-standing and trusted relationships with pediatric

[15] Standard of Care on Screening for Childhood Lead Poisoning, at https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx accessed February 5, 2025.

medical providers countywide and is committed to ensuring that providers and patients will continue to receive education, tools, and resources needed to properly inform families and assess for those at risk of lead exposure.

Increasing lead testing rates is challenging but presents opportunities for improvement. Our Child Lead Poisoning Prevention grant includes a number of activities targeting children who are found to be lead exposed, including nurse case management and environmental assessment, abatement, and mitigation. However, the grant does not provide local health jurisdictions, (including the County), with any funding or duty for performing/ assuring blood lead testing itself. That responsibility lies solely with clinical healthcare providers to perform the tests and the health insurer to cover the costs. Medi-Cal recipients are already required to be tested at appropriate ages as a function of enrollment and the costs of testing are fully covered by the program.

Given the fact that there are such a large number of at-risk children enrolled, coupled with the reality that there is significant room for improvement in Medi-Cal testing rates, it is reasonable to conclude that any success in improving Medi-Cal testing rates is likely to have a measurable effect on the number of at-risk children being tested. County rates of testing correlate closely with statewide rates; thus, efforts that increase assurance at the state regulatory level should have similar effects at the County level. Public Health recommends a few strategies that would initially focus on Medi-Cal enrollees as a target population to improve lead testing rates:

1. Increase administrative advocacy with DHCS, which administers the Medi-Cal program for the state and is responsible for assuring compliance with all applicable regulations. Your Board could consider sending a five-signature letter to the director of DHCS, urging more effective assurance activities to ensure that Medi-Cal enrollees are being tested as statutorily required. The County could also pursue other advocacy strategies with through statewide partners to increase assurance activities. Improving compliance with current requirements under State and federal law through the creation or expansion of specific incentives/penalties could also be explored.

2. As more Medi-Cal recipients get enrolled in managed care organizations (MCO), rather than fee-for-service structures, these MCOs accept the responsibility from DHCS to engage in quality assurance (QA) and quality improvement (QI) activities with their contracted providers. This presents an opportunity for partnership and collaboration within the County, as Public Health has existing relationships with the larger Medi-Cal MCOs in the County, (e.g., LA Care, Health Net, and Kaiser Permanente). The County may not have specific authority to leverage responses from these entities, but there is little cost or risk in approaching these organizations to collaboratively investigate what current QA and QI activities and plans exist regarding improving rates of lead testing and see how the County might be positioned or resourced to assist in this effort.

3. Although the large majority of at-risk children presumably receive their healthcare from external community medical providers and not through County-run healthcare, it would still be advisable to review the success of the Los Angeles County Department of Health Services (DHS) in ensuring current clinical requirements for lead exposure prevention and testing are met. Public Health, via its own Child Lead Poisoning Prevention Program,

already has a strong relationship with DHS pediatric services to facilitate identification of lead-exposed children and can further leverage this relationship to assist DHS if available data indicates opportunity for improvement. Any QI plan that may evolve as a result could serve as a model that might be offered more widely at a larger scale to external medical providers.

Please let me know if you have any questions or would like additional information.

BF:pb

Cc: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel