



Legislative Fiscal Bureau

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Joint Committee on Finance

Paper #390

Lead Exposure and Poisoning Prevention (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 173, #13 and Page 195, #1]

CURRENT LAW

Blood Lead Level Testing. All children enrolled in medical assistance (MA) and the children's health insurance program (CHIP) are required to receive blood lead level (BLL) screening tests at ages 12 months and 24 months. In addition, any child between the ages of 24 and 72 months with no record of previous blood lead screening tests must receive one.

Under MA's early and periodic screening, diagnostic and treatment (EPSDT) benefit, MA provides comprehensive coverage for any MA service listed in federal law that is medically necessary to correct or ameliorate defects in physical and mental illnesses and conditions identified by the screening services, whether or not the service is otherwise covered under the state's MA plan. For this reason, children who are found to have elevated BLLs are eligible for a wide range of treatment services, including environmental lead investigations (ELIs).

2017 Act 59 changed the statutory definition of lead poisoning or lead exposure from 10 mcg/dL of blood to a reduced threshold of five or more mcg/dL of blood. The new state standard is consistent with the current standard used by the Centers for Disease Control and Prevention (CDC).

Environmental Lead Investigations (ELIs). The MA program reimburses agencies that conduct lead investigations in the home or primary residence of a child found to have an elevated BLL. Under federal law, lead investigations must be conducted by a credentialed health practitioner who meets qualifications established by the state, and must be undertaken to identify the source of lead exposure to a child with an elevated BLL.

In the 2017-19 biennium, the Legislature and the Department of Health Services (DHS)

made several changes to the state's MA program to increase the number of ELIs conducted. First, as previously indicated, Act 59 broadened the definition of lead poisoning and lead exposure to the current five mcg/dL, a finding that triggers an ELI for a home occupied by child enrolled in MA. Second, Act 59 increased, from \$105.26 to \$800, MA reimbursement for ELIs. Third, effective for dates of service after March 1, 2018, the MA program no longer requires prior authorization for ELI services.

Current ELI covered services include: (a) an initial comprehensive lead investigation; (b) follow-up lead clearance investigations; and (c) nursing education visits related to lead poisoning performed by registered nurses. All persons conducting investigations must be DHS certified as a lead hazard investigator or risk assessor.

Lead Abatement. The state does not administer any programs that fund abatement of lead hazards.

BadgerCare Plus HMO Blood-Lead Testing Standards. DHS imposes a \$10,000 fine on BadgerCare Plus HMOs that fail to meet benchmarks standards for BLL testing for children. In 2019, the standard requires HMOs to test of 80.1% of enrolled children by age two.

GOVERNOR

Provide \$23,446,000 (\$5,282,400 GPR and \$18,163,600 FED) in 2019-20 and \$19,558,700 (\$6,467,200 GPR and \$13,091,500 FED) in 2020-21 and 2.14 GPR positions, beginning in 2019-20, to support lead exposure prevention activities, as described below.

CHIP Funding for Lead Abatement. Provide \$17,973,400 (\$2,136,200 GPR and \$15,837,200 FED) in 2019-20 and \$14,335,700 (\$3,321,500 GPR and \$11,014,200 FED) in 2020-21 for lead abatement to residential properties occupied by children and pregnant women eligible for MA or the children's health insurance program (CHIP).

Abatement for Properties Not Occupied by CHIP-Eligible Children. Provide \$1,000,000 GPR annually for lead abatement grants for properties not occupied by children enrolled in MA or CHIP.

Abatement Training Grants. Provide \$300,000 (\$50,900 GPR and \$249,100 FED) in 2019-20 to fund lead abatement training grants, with the intent of expanding the certified lead abatement workforce.

Public Health Outreach. Provide \$500,000 GPR annually for grants to physician groups to establish a peer-to-peer public health outreach program to increase lead testing among children at risk for lead poisoning.

State Staff. Provide \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21 and 2.14 positions, beginning in 2019-20, to assist in the administration of an expanded lead exposure and poisoning prevention program.

HMO Incentives. Provide \$3,500,100 (\$1,422,800 GPR and \$2,077,300 FED) annually to increase pay-for-performance incentives to BadgerCare Plus HMOs to encourage HMOs to meet state and federal BLL testing standards.

Table 1 summarizes the funding that would be provided under these items.

TABLE 1

Summary of Proposed Lead Exposure and Poisoning Prevention Funding

	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
Lead Abatement Grants	\$2,136,200	\$15,837,200	\$17,973,400	\$3,321,500	\$11,014,200	\$14,335,700
Non-CHIP Abatement	1,000,000	0	1,000,000	1,000,000	0	1,000,000
Workforce Training	50,900	249,100	300,000	0	0	0
Public Health Outreach	500,000	0	500,000	500,000	0	500,000
State Positions	172,500	0	172,500	222,900	0	222,900
HMO Incentives	<u>1,422,800</u>	<u>2,077,300</u>	<u>3,500,100</u>	<u>1,422,800</u>	<u>2,077,300</u>	<u>3,500,100</u>
Total	\$5,282,400	\$18,163,600	\$23,446,000	\$6,467,200	\$13,091,500	\$19,558,700

In addition, the bill would modify the lead poisoning or lead exposure prevention grant program to specify that grants may be made for residential lead hazard abatement, residential lead hazard reduction, and lead abatement worker training.

DISCUSSION POINTS

Background

1. Exposure to lead can cause significant physical problems in children that can persist for a lifetime. Lead interferes with the normal development of a child's brain, and can lead to conditions such as reduced intellectual abilities, developmental disabilities, and behavioral problems. According to a 2010 report by the Wisconsin Childhood Lead Poisoning Elimination Plan Implementation and Oversight Committee, the average lifetime cost of lead poisoning is estimated to be approximately \$46,000 per child.

2. Young children are at the greatest risk of lead exposure because they often crawl on floors, have frequent hand-to-mouth activity, and eat nonfood items. Young children are more affected by lead exposure than older children and adults because of their smaller body size and weight.

3. The Department's 2016 Report on Childhood Lead Poisoning indicates that lead based paint found in older homes is the primary cause of lead exposure for children in Wisconsin. Ninety percent of children with lead poisoning in Wisconsin were first identified with lead exposure while living in housing built before 1950.

4. The number of children under the age of six tested for elevated BLLs generally increased

between 1996 and peaked in 2010, and declined until 2016, when it increased slightly. The percentage of children who are tested that have elevated BLLs continues to decrease, likely due to a gradual increase in the percentage of children who live in homes constructed after 1950. In 1978, the Consumer Product Safety Commission banned the consumer use of lead based paint and toys and furniture coated with lead based paint.

5. Table 2 presents information on the total number of Wisconsin children under the age of six who were tested for elevated BLLs, and the number and percentage of children who were tested who were found to have elevated BLLs for calendar years 2006 through 2016, the last year for which information is available. In 2016, 86,771 children under the age of six were tested, representing approximately 20% of the number of children under age statewide. In that year, 60% of all one-year olds, 48% of all two-year olds, and 14% of all children ages three through five who were not previously tested in the state received tests for elevated BBLs.

TABLE 2

**Blood Lead Level Testing -- Wisconsin Children under Age Six
Calendar Years 2006 through 2016**

<u>Year</u>	<u>Number of Children Tested</u>	<u>Tested Children with BLL > 5mcg/dL</u>	
		<u>Number</u>	<u>Percent</u>
2006	81,934	11,130	13.6%
2007	92,536	11,172	12.1
2008	97,043	9,059	9.3
2009	101,672	9,092	8.9
2010	106,590	7,630	7.2
2011	105,326	6,999	6.6
2012	98,582	6,175	6.3
2013	94,665	4,894	5.2
2014	89,258	3,981	4.5
2015	86,316	3,949	4.6
2016	86,771	4,348	5.0

6. Children enrolled in Medicaid and other children in families with low income are at greater risk of lead poisoning than other children, primarily because they tend to live in older homes. However, in 2016, only 32% of children enrolled in Medicaid received the required testing at both one and two years of age, even though states must ensure that children enrolled in Medicaid receive required screenings. DHS staff believe that many physicians follow a different testing standard established by the Healthcare Effectiveness Data Information Set (HEDIS), which only requires physicians to report one BLL test for a child by the time the child reaches age two. In addition, the current BadgerCare Plus HMO contracts penalize HMOs that fail to meet the HEDIS standard, rather than the federal Medicaid standard.

7. Higher rates of elevated BLLs are found in certain areas of the state, notably the cities of Milwaukee and Racine. For this reason, the 2016 DHS report recommends that universal testing of all children living in both cities, such that: (a) all children should have three BLL tests before they

reach the age of three; and (b) children ages three through five should be tested annually if they meet specified criteria, such as if they live in a house built before 1950, or have a sibling or playmate with lead poisoning. In other areas of the state, the report encourages health care provider to consider four factors to determine whether a child is at risk for lead poisoning and should be tested. These factors include whether: (a) the child lives in a home built before 1950; (b) the child lives in a house built before 1978 with recent or ongoing renovations; (c) the child has a sibling or playmate with lead poisoning; or (d) the child is enrolled in Medicaid or the supplemental food program for women, infants and children (WIC).

8. Generally, efforts to encourage BLL testing result in additional ELIs and lead hazard abatement efforts. However, several obstacles to abatement remain -- primarily the lack of workers who are certified to conduct lead hazard abatement activities, and the cost of lead hazard removal projects.

Lead Abatement -- Project Funding and Workforce

9. Lead abatement involves the removal of lead-based paint from homes of children who have been identified as having elevated BLLs or who are at risk of lead poisoning. Lead abatement services must be conducted by contractors who have been trained and certified by DHS to perform the work.

10. In August, 2018, there were 161 certified lead abatement companies in the state, and 474 certified abatement workers, about half of the number of certified abatement workers that there was in 2013. The Department attributes the decline in the number of certified lead abatement workers to an improving economy, which leads to more new construction projects, and therefore a strain on the supply of skilled workers who might otherwise pursue certification and work on lead abatement projects.

11. The Department estimates that with this additional funding, it could increase the total number of abatement workers and supervisors from 635 to 1,074. The administration argues that increasing the number of certified abatement workers is needed to quickly and effectively meet the increased demand for abatements that would result from the additional abatement funding in the bill.

12. Most of the additional funding that would be provided in the bill (approximately \$18 million in 2019-20 and \$14.3 million in 2020-21) to fund lead abatement projects for homes occupied by children enrolled in CHIP with elevated BLLs. The EPA estimates that lead paint abatement projects cost an average of \$8 to \$15 per square feet, and that the average abatement project costs approximately \$10,000. DHS estimates that the CHIP funding in the bill could support approximately 2,250 abatement projects in the 2019-21 biennium, at an average cost of \$14,360 per project. The actual number of abatement projects that could be funded with the amounts in the bill would depend on the scope of these projects.

Non-CHIP Lead Abatement

13. In addition to the CHIP funding, the bill also includes GPR funding for grants to conduct lead abatements in housing not occupied by properties not occupied by children enrolled in MA or CHIP. According to the Department's 2016 report, at least 650 children in the state were found to be

have lead poisoning, but were not eligible for MA. To meet the needs of these children, the administration argues that additional funding should be provided for abatement of non-CHIP occupied homes, and estimates that this funding could support 143 non-CHIP eligible properties in the 2019-21 biennium.

State Staff

14. The bill would provide \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21 and 2.14 positions, beginning in 2019-20, for lead exposure and poisoning prevention activities. Of these positions, 1.0 would be a public health educator project position in the Division of Public Health, to administer the public health outreach initiative. The other 1.14 positions would be permanent positions to enhance the Department's lead poisoning prevention programs. The Department indicates that it would reallocate 2.86 existing federal positions to supplement the permanent 1.14 GPR positions, to provide a total of 4.0 positions for the program. These positions would replace 4.0 contract positions currently conducting program activities (a contract specialist, a public health nurse, a database specialist, and an epidemiologist).

Peer to Peer Outreach Efforts

15. The bill includes \$500,000 GPR annually for DHS to provide grants to physician groups to establish a peer-to-peer public health outreach program to increase lead testing for children most at risk of lead poisoning. The administration proposes to establish a peer-to-peer public health outreach program to encourage providers to exceed HEDIS BLL testing. The Department would allocate funding through a RFA process to a physician group. The awardee would be responsible for developing and conducting broad-based lead trainings for MA HMOs and develop partnerships between providers who have high lead testing rates with providers who have low BLL testing rates.

16. The administration indicates that peer-based outreach program could foster greater compliance and engagement among providers. Moreover, partnering high-performing providers with low-performing providers could cultivate a collaborative exchange of ideas to address gaps in testing, identify areas of unmet need, and develop innovative solutions designed to increase lead testing among children at risk for lead poisoning.

HMO Incentive Payments

17. Finally, the bill would provide \$3,500,100 (\$1,422,800 GPR and \$2,077,300 FED) annually to increase pay-for-performance incentives to BadgerCare Plus HMOs. This item would provide funding for incentive payments to increase the percentage of children tested. The amounts are based on approximately 0.25% of BadgerCare Plus HMO capitation payments.

18. Table 3 provides summary information on screening blood lead tests performed for MA-enrolled children in calendar years 2013 through 2017, the last year for which information is available.

19. Currently, DHS imposes a \$10,000 fine on HMOs for failure to meet the HEDIS standards for blood-lead testing for children, which, in 2019, is testing of 80.1% of enrolled children by age two. In 2017, HMOs were required to meet the BLL screening target of 79.5%, but two-thirds of the HMOs did not meet the target.

TABLE 3**Percent of Medicaid-Enrolled Children under Age Six Tested for Blood Lead Levels
Calendar Years 2013 through 2017**

<u>Year</u>	<u>Children Less Than Six Months Old</u>	<u>Children Six through 16 Months Old</u>	<u>Children Ages 17 Months through 29 Months Old</u>	<u>Children Ages 30 Months through 71 Months Old</u>	<u>Children Ages 30 Months through 71 Months that were Never Previously Tested</u>	<u>Percent of Total Children Tested under 72 Months</u>	<u>Percent of Children under 72 Months for Whom Testing was Required</u>
2013	0.2%	77.8%	59.8%	19.8%	14.4%	34.4%	52.9%
2014	0.2	71.9	54.9	19.1	13.3	32.3	49.0
2015	0.2	71.8	53.6	18.6	13.3	32.2	48.5
2016	0.3	70.6	53.2	18.7	13.9	32.1	47.6
2017	0.3	69.5	54.7	19.2	20.1	32.7	52.1

20. Although the table shows the percentage of MA-enrolled children, by age category, that received a BLL test in each year, it does not show the percentage of children that received all the BLL tests that a child would need to meet the federal BLL testing standard. For this reason, it is difficult to assess how successful HMOs would be in demonstrating that they meet the federal MA standard. DHS indicates that any funding budgeted for, but not paid under the incentive program would not be expended for other purposes, such as other HMO incentive payments.

21. There are likely many reasons why an HMO may not be able to meet the federal MA program standards for BLL testing. First, physicians may use discretion in determining if a BLL test is necessary, particularly if a child does not live in a home constructed before 1979 or had a recent BLL test. Second, compliance with the federal standard requires parents and other caregivers to schedule and keep appointments for EPSDT (HealthCheck) check-ups, factors not directly controlled by the HMO.

Use of CHIP Funding

22. The administration intends to maximize the use of federal funds to support these activities by expending federal CHIP allotments, which provide an enhanced match rate for CHIP eligible services, relative to the federal matching rate that applies to most MA expenditures (approximately 59% of eligible costs).

23. Federal CHIP funds are provided to states to increase healthcare coverage for children who would not otherwise be eligible under the standard Medicaid program. In Wisconsin, as with most states, federal CHIP funds are used, along with federal Medicaid funds, in a combined MA program. Generally, children covered under CHIP are children in households with income above 150% of the federal poverty line (FPL), but less than 300% of the FPL, although the CHIP thresholds vary by age of the child.

24. The state and federal share of the CHIP funding amounts in the bill are based on the CHIP federal matching rate applicable for the biennium (85.92% in 2019-20, and to 74.42% in 2020-21.) The reduction in the FMAP for CHIP reflects that the higher CHIP rate was established on a

temporary basis in the federal Affordable Care Act. No future decrease in the federal CHIP FMAP is anticipated.

25. Authorized under the federal CHIP program, health services initiatives (HSIs) allow states to use a portion of CHIP funding to provide preventative services and interventions that would not otherwise be eligible for federal matching funds. Examples of HSIs from other states include a Massachusetts initiative to prevent youth violence through after school programs aimed at mitigating the consequences of trauma and promoting healthy development, and a Missouri initiative to provide immunizations to low-income families that are less likely to receive the recommended immunizations.

26. As part of the CHIP program, HSIs are funded through a combination of state and federal funding, according to the CHIP FMAP. The federal portion is funded through a state's available CHIP allotment for a fiscal year. HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under federal law, claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of CHIP funds claimed by the state each quarter. Within the 10 percent limit, states must first fund costs associated with administration of the CHIP plan, but any funds left over may be used for an HSI. In addition, states must assure in the CHIP plan that they will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

27. CMS has encouraged states to consider initiatives to increase blood lead level screening for young children, and has approved HSIs for lead abatement activities in Michigan, Indiana, Maryland, and Ohio. Similar to the approved initiatives in these states, DHS is proposing to implement a lead abatement HSI in Wisconsin.

28. The Department intended to begin funding lead abatement services in 2018-19, using CHIP funds and state matching funds from base resources. Accessing federal CHIP funds for this purpose requires an amendment to the state's federal CHIP plan, and, under provisions enacted in 2017 Wisconsin Act 370, such plan amendments must be approved by the Joint Committee on Finance prior to submittal to CMS. On February 14, 2019, the Department submitted a proposed plan amendment to the Committee under a 14-day passive review process. However, an objection to the plan amendment was registered. To date, no meeting had been scheduled to review the plan amendment. Consequently, DHS had not implemented this provision. This item would provide funding in the 2019-21 biennium. However, citing a recent court ruling that suspended enforcement of provisions in Act 370, DHS submitted the proposed amendment to the state's CHIP plan in March, 2019. CMS is currently reviewing the proposed amendment.

29. The Governor's budget recommendations reflect a comprehensive approach to addressing lead poisoning among children, as it includes initiatives to increase BLL testing among MA-eligible children (by funding MA HMO incentive payments and public health outreach efforts targeted to physicians), which would result in an increase in the number of environmental lead investigations (ELIs) conducted by local public health agencies. In addition, for the first time, state funding would be provided to support abatement projects for houses with lead hazards, and state funding would be provided to increase the number of workers who can safely eliminate lead hazards. Further, the proposal maximizes the use of enhanced federal matching rates available under CHIP.

30. In light of the importance of reducing the number of lead poisoned children in the state and the availability of significant federal CHIP and MA funding that is available to support efforts to reduce lead poisoning in the state, the Committee could adopt the Governor's recommendations (Alternative 1). Alternatively, the Committee could choose to delete one or more components from this item (Alternatives 2a, 2b, 2c, 2d, 2e, or 2f). Finally, the Committee could take no action on this item (Alternative 3).

ALTERNATIVES

1. Adopt the Governor's recommendations.

ALT 1	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,749,600	2.14	\$0	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$43,004,700	2.14	\$0	0.00

2. Modify the bill by selecting one or more of the following options. [If the Committee selects more than one option, the fiscal change to the bill is cumulative. However, the change to base is not cumulative.]
 - a. Delete funding for lead abatement grants funded from GPR and surplus FED administrative funding available under CHIP. Reduce funding in the bill by \$17,973,400 (-\$2,136,200 GPR and -\$15,837,200 FED) in 2019-20 and by \$14,335,700 (-\$3,321,500 GPR and -\$11,014,200 FED) in 2020-21.

ALT 2a	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$6,291,900	2.14	- \$5,457,700	0.00
FED	<u>4,403,700</u>	<u>0.00</u>	<u>- 26,851,400</u>	<u>0.00</u>
Total	\$10,695,600	2.14	- \$32,309,100	0.00

- b. Delete funding for abatement grants for non-CHIP properties. Reduce funding in the bill by \$1,000,000 GPR annually.

ALT 2b	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$9,749,600	2.14	- \$2,000,000	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$41,004,700	2.14	- \$2,000,000	0.00

- c. Delete funding for workforce training grants. Reduce funding in the bill by \$300,000 (-\$50,900 GPR and -\$249,100 FED) in 2019-20.

ALT 2c	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,698,700	2.14	- \$50,900	0.00
FED	<u>31,006,000</u>	<u>0.00</u>	<u>- 249,100</u>	<u>0.00</u>
Total	\$42,704,700	2.14	- \$300,000	0.00

d. Delete funding for public health outreach. Reduce funding in the bill by \$500,000 GPR annually.

ALT 2d	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$10,749,600	2.14	- \$1,000,000	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$42,004,700	2.14	- \$1,000,000	0.00

e. Delete 2.14 GPR positions for the Division of Public Health and \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21.

ALT 2e	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,354,200	0.00	- \$395,400	- 2.14
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$42,609,300	0.00	- \$395,400	- 2.14

f. Delete funding for HMO incentive payments (-\$1,422,800 GPR and -\$2,077,300 FED annually).

ALT 2f	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$8,904,000	0.00	- \$2,845,600	0.00
FED	<u>27,100,500</u>	<u>0.00</u>	<u>- 4,154,600</u>	<u>0.00</u>
Total	\$36,004,500	0.00	- \$7,000,200	0.00

3. Take no action.

ALT 3	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$0	0.00	- \$11,749,600	- 2.14
FED	<u>0</u>	<u>0.00</u>	<u>- 31,255,100</u>	<u>0.00</u>
Total	\$0	0.00	- \$43,004,700	- 2.14

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