for ending an era of enormous expansion and example to the rest of the world, which the Western World is just beginning to follow on. It is hard to believe.

But listen to what the chairman said and hope in the next 24 hours we can do this, because we can. And, sir, we must.

Under the rules, President Ford, I believe, has free access to the floor. I wish he would come on here and talk to each of us one on one.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. ROTH. First of all, let me thank the distinguished ranking member of the Finance Committee, Senator MOYNIHAN, for his eloquent remarks. All I can say is, we must not let that happen. And with the kind of bipartisan spirit we had in the Finance Committee, it will not happen.

MORNING BUSINESS

Mr. ROTH. Mr. President, I ask unanimous consent that there now be a period for the transaction of morning business, with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROTH. Mr. President, I yield the floor.

Mr. REED addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. I would like to be recognized to conduct morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Mr. REED. I ask unanimous consent that privileges of the floor be granted to Rebecca Morley of my staff.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REED. I thank the Chair.

NATIONAL CHILDHOOD LEAD POISONING PREVENTION WEEK

Mr. REED. Mr. President, I rise today to speak with respect to National Childhood Lead Poisoning Prevention Week. Because of the efforts of my colleagues, Senator COLLINS, Senator TORRICELLI, and myself, this Senate passed a bipartisan resolution a last week to commemorate, during the week of October 24 to 30, National Childhood Lead Poisoning Prevention Week.

I think it is appropriate to recognize this problem that is taking place throughout this country and also recognize what we are trying to do to alleviate this great problem.

As a preliminary point, let me commend my colleague, Senator COLLINS, for her great efforts in this regard. She has been a true leader in this issue. She has been someone who has fought the good fight with respect to this problem. She has participated legislatively. I was very pleased and honored a few weeks ago to have her join me in Providence, RI, for a hearing on this issue. I look forward to joining her in a few weeks in Maine so we can examine the experience in her home State.

I also want to commend my colleague, Senator TORRICELLI, who also is very active as a leader in this effort. Indeed, Senator TORRICELLI and I have introduced legislation, the Children's Lead SAFE Act of 1999, which is critically important to the future of our children in the United States.

This importance has been underscored and highlighted by two recent reports—one earlier this year in January of 1999 by the General Accounting Office, and another report that has been released recently under the auspices of the Alliance To End Childhood Lead Poisoning and the National Center for Lead-Safe Housing.

Both of these reports underscore the need for additional efforts to eliminate childhood exposure to lead and also to provide additional support for screening and treatment of children who are exposed to environmental lead.

Regrettably, there are too many children in this country who are exposed to lead, typically through old lead paint that may be in their home. It is particularly critical and crucial to children who are at a very young age, under the age of 6, because their body is much more likely to absorb this environmental hazard, and also because those are exactly the times in which brain nervous systems are developing, where cognitive skills are being developed. We know lead is the most pernicious enemy of cognitive development in children.

In the United States, too many children are poisoned through this constant exposure to low-levels of lead in their atmosphere. This exposure leads to reduced IQ, problems with attention span, hyperactivity, impaired growth, reading and learning disabilities, hearing loss, and a range of other effects.

Lead poisoning is entirely avoidable, if we have the knowledge and the resources and the effort to prevent young children from being exposed to lead.

In January of this year, as I indicated, the General Accounting Office highlighted the problems in the Federal health care system with respect to lead screening and followup services for children.

We have policies that require all Medicaid children to be screened for lead. Sadly, we have not achieved that level of 100 percent screening. We want to reach that goal. Then after screening all of the children in the United States who may be vulnerable to lead poisoning, we want to ensure these children have access to followup care. Identifying poisoned children is only the first step and is only effective when coupled with proper follow-up care.

Most recently, we received information about that follow-up care from a report, the title of which is: ''Another Link in the Chain: State Policies and Practices for Case Management and Environmental Investigation for Lead-Poisoned Children.'' As I indicated, this report was sponsored by the Alliance To End Childhood Lead Poisoning and the National Center for Lead-Safe Housing.

This report presents a State-by-State analysis of data which suggests, first, there have been some innovative steps taken by the States, but unfortunately there are disappointing gaps in the screening and treatment of children who are exposed to lead throughout the United States.

There is also a great range among the States in their response to this problem of childhood lead poisoning. In my own State of Rhode Island, we have taken some very aggressive steps. Last week, we dedicated a lead center in Providence, RI, which provides comprehensive services for lead-poisoned children, including parent education, medical followup for children who have been exposed, and transitional housing. Many times the source of the pollution is in the home of these children, and because of their low income, there is no place for them to go unless there is this transitional housing. This is an innovative step forward. I am very pleased and proud to say it has taken place in my home State.

If you look across the Nation, you find much less progress. Nearly half of the States have no standards for case management and, thus, the quality of care lead poisoned children receive is often not consistent with public health recommendations. There is no real way to ensure these children are getting the type of care they need because there are no case management policies. Only 35 States have implemented policies that address when an environmental investigation should be performed to determine the source of a child's lead poisoning. There are many States where there is no way to determine where the source of the pollution is coming from that is harming the child.

In addition, the report points out that despite the availability of Medicaid reimbursement for environmental investigation and case management, more than half the States have not taken advantage of this Medicaid reimbursement. In addition, despite the emphasis we have in Medicaid on screening children, only one-third of the States could report on how many of their lead poisoned children were enrolled in Medicaid, suggesting that screening data are not being coordinated, and there really is not comprehensive, coherent screening policy in all too many States.

Senator TORRICELLI and I have proposed legislation that would address these deficiencies. The legislation will improve the management information systems so States know how many children are screened and how many children have been exposed. We also encourage them to integrate all the different agencies and institutions and programs that serve children so we can

have a comprehensive approach. This would include involving the WIC program in the screening, early Head Start, maternal and child health care block grant programs, so we have a comprehensive approach to identifying, treating, following up and educating with respect to lead exposure.

We are committed to doing that. We are committed to ensuring that every child in this country, particularly those children who are beneficiaries of the Medicaid system, have this kind of screening and followup.

Unfortunately, we have found too many States that are not following through on their obligations. Of the 38 States that have enrolled Medicaid children to managed care plans, only 24 reported that their State's contract with the managed care organization contained any language about lead screening or treatment services. So, many States are leaving it up to the managed care company or merely leaving it up to chance whether or not there are good protocols to follow up on lead exposure.

In addition to that, more than 40 percent of States reported that no funding is available to help pay for even a portion of the hazard control necessary to make a home lead safe for a lead-poisoned child. There are not the resources to help these families cope with the reality of homes that are literally poisoning and harming their children. That is one reason why I joined my colleague, Senator TORRICELLI, to address this problem with respect to the Children's Lead SAFE Act of 1999. We would like to see clear and consistent standards for screening and treatment to ensure that no child falls through the cracks. We would to help communities, parents and physicians take advantage of every opportunity they have to detect and treat lead poisoning.

This bill is just one element in a comprehensive, coherent approach to eliminate this preventable disease that afflicts too many children in this country today.

I was pleased that during the appropriations process, the Senate supported the President's request for full funding of the lead hazard control grants program—indeed, particularly pleased when the conferees agreed with the Senate and maintained this funding. It is absolutely critical. We will continue to press forward in terms of screening and treatment, in terms of reducing lead hazards in the homes of children, and in terms of education, so there is no place in this country that fails to recognize the gravity of this situation where children are poisoned by exposure to lead.

Indeed, that is why we are here today. This week is National Childhood Lead Poisoning Prevention Week. We hope by reserving 1 week a year to emphasize the challenges we face, to emphasize the steps which must be taken in the future, we can galvanize additional support so there is no child in this country who is poisoned by lead, whose development—physical, mental, social development—is harmed by such exposure.

At the heart of this effort is the work of many people, but, once again, I thank my colleague and friend, Senator SUSAN COLLINS, who has taken it upon herself to charge forward to make this hope of a lead-safe environment for all our children a reality. I am pleased to be with her sponsoring this resolution, sponsoring this week of commemoration and also, in the days ahead, working to ensure that all the children are as free as we can make them from the harm and the danger of lead exposure.

I ask unanimous consent that the Presidential message recognizing National Childhood Lead Poisoning Prevention Week and the executive summary of ''Another Link in the Chain,'' be printed in the RECORD, following my statement.

There being no objection, the materials were ordered to be printed in the RECORD, as follows:

THE WHITE HOUSE,
Washington, October 20, 1999.

Warm greetings to everyone observing National Childhood Lead Poisoning Prevention Week.

As America's children begin their exciting journey into the 21st century, one of the greatest gifts we can give them is a healthy start. Sadly, however, many children face needless obstacles to healthy development in their own homes. Among the most devastating of these obstacles is lead poisoning. Today nearly 5 percent of children between the ages of 1 and 5 suffer from this condition. While any child can be susceptible to lead poisoning and its effects, low-income children are at a significantly higher risk, since most children are poisoned by lead-based paint and lead-contaminated dust and soil that are found in older, dilapidated housing. For African-American children living in these conditions, the rate of those who suffer from lead poisoning is a staggering 22 percent.

The effects of lead poisoning can be serious and irrevocable. Even low levels of exposure to lead can hinder children's ability to learn and thrive, reducing their IQ and attention span and contributing to learning disabilities, hearing loss, impaired growth, and many other developmental difficulties. My Administration, through the Department of Housing and Urban Development and the Environmental Protection Agency, has taken important steps to eliminate the threat of lead poisoning. We have provided funding for such efforts as removing lead-based paint from housing built prior to 1978, when such paint was outlawed. We have also promoted increased blood testing of young children to determine the levels of lead in their blood.

However, when our children's well-being is at stake, we must do more. I commend the concerned citizens and organizations participating in this year's observance for raising awareness of the dangers of lead poisoning and for teaching families and communities how to prevent it. I urge all Americans to take this occasion to learn more about lead poisoning and to take part in local, state, and national efforts to create a healthier environment for our children.

Best wishes for a successful week.

BILL CLINTON.

CHAPTER 1—EXECUTIVE SUMMARY

The first line of defense in protecting children from lead poisoning is primary prevention, which means controlling lead hazards before children are ever exposed to lead. However, the broad distribution of lead in the U.S. housing stock has made achieving primary prevention for all children an elusive goal. As a result, secondary prevention strategies continue to play a vital role in protecting children from lead poisoning. Secondary prevention entails identifying the lead-poisoned child, providing medical care and case management, identifying the source of the child's lead exposure (environmental investigation), and then ensuring that any lead hazards identified are controlled to prevent the child's further exposure to lead.

Over the past few years, there has been considerable public attention to and controversy surrounding policies for screening young children for lead poisoning. There has also been considerable discussion about primary prevention and housing-based approaches to primary prevention, as a consequence of enactment of Title X and federal funding for the HUD Lead Hazard Control Grants program. In contrast, there has been little discussion of what actually happens once a lead-poisoned child is identified. The Alliance To End Childhood Lead Poisoning and the National Center for Lead-Safe Housing agreed that it was time to reexamine the response to lead-poisoned children nationwide. We decided that characterizing the case management and environmental investigation services now being provided in each state would be a useful first step. We hope this report's documentation of state policies will help sharpen discussion and decision-making at many levels. This report is timely for at least four reasons.

First, this report provides the information needed to ensure that case management and environmental investigation systems are ''in good working order'' to handle the increased caseloads that can be expected from expanded lead screening of high-risk children. Recent reports from the General Accounting Office (GAO) have focused the spotlight on the failure of federal health programs to screen high-risk children for lead poisoning. GAO documented that just 19% of Medicaid-enrolled children aged 1 through 5 are being screened as required by law, and that the majority of children needing case management and environmental investigation are enrolled in Medicaid. As a consequence, considerable attention is being paid now to improving lead screening rates among Medicaid children. In addition, many states are developing CDC-recommended lead screening plans to identify and target the highest-risk children for lead screening.

Second, this report raises a number of policy and program issues that should be considered as states seek to ensure that lead-poisoned children enrolled in Medicaid managed care plans are provided with appropriate follow-up care. Many states are still developing or fine-tuning their mechanisms for overseeing and coordinating care with Medicaid managed care plans, as well as state Children's Health Insurance Programs.

Third, this report can help to inform a number of pending policy decisions. The Health Care financing Administration has been receiving criticism from many quarters for its policy prohibiting Medicaid reimbursement for analysis of the environmental samples needed for an adequate environmental investigation to identify the lead hazards in a poisoned child's home. In addition, the Centers for Disease Control and Prevention's Advisory Committee on Childhood Lead Poisoning Prevention is currently reviewing the evidence base for case management services. Finally, U.S. Senators Robert Torricelli (D–NJ) and Jack Reed (D–RI) and U.S. Representative Robert Menendez (D–NJ) are introducing federal legislation to address these issues in Congress.

Fourth, the sharp decline in the number of children with elevated blood lead levels documented by NHANES III, Phase 2 offers opportunities never before available for using screening and follow-up measures to advance prevention. For the first time, the caseload of lead-poisoned children in jurisdictions historically overwhelmed by the number lead-poisoned children has become ''manageable.'' We have a responsibility to respond promptly and humanely to children with elevated blood lead levels as well as the opportunity to use these interventions to advance prevention. Childhood lead poisoning is entirely preventable. But achieving this goal requires us to sharpen our tools and redouble prevention efforts, rather than being complacent or uncritically flowing ''established procedures'' by rote.

SCOPE OF THE SURVEY

The scope of this survey and report is limited to describing and evaluating the quality of self-reported state policies and practices for environmental investigation and case management. This report therefore could not assess state primary prevention initiatives, lead screening policies and performance, or even medical care provided to lead-poisoned children. The most effective state programs are those that succeed at primary prevention. Once a child is exposed to lead, the overall effectiveness of the response must be judged by performance in all three areas of secondary prevention—and a single weak link in the chain of secondary prevention activities can undermine the effectiveness of the entire response. Having exemplary environmental investigation and case management services is useless if the state fails to screen children at risk for lead poisoning to identify those with elevated blood lead levels. Similarly, providing good environmental investigation and case management services is pointless if these activities do not trigger action to control identified lead hazards.

It is also important to be clear about what is meant by each key term. ''Environmental investigation'' means the examination of a child's living environment, usually the home, to determine the source or sources of lead exposure for a child with an elevated blood lead level. For the purposes of this report, ''case management'' means coordination, provision, and oversight of the services to the family necessary to ensure that lead-poisoned children achieve reductions in blood lead levels. In addition, case management includes coordination, but not provision and oversight, of the clinical or environmental care.

SURVEY METHODOLOGY AND RESPONSES

To gather the information about current policies and practices for case management and environmental investigation, an initial survey and a supplementary survey were sent to directors of state lead poisoning prevention programs. In states where these programs do not exist, we identified knowledgeable respondents by contacting surveillance grantees of the Centers for Disease Control and Prevention (CDC) or other program staff responsible for lead services (often a division of the state health department). Ultimately, we received responses from all 50 states and the District of Columbia. We also received responses from 15 local lead programs, which allowed us to better characterize several important dimensions of current practice of state programs.

KEY FINDINGS AND RECOMMENDATIONS ON INITIATING SERVICES

State blood lead reporting systems

Central reporting of elevated blood lead levels is critical to ensuring timely follow-up care for lead-poisoned children. Although nearly all (47) states have a reporting system for blood lead levels, the utility of the systems for timely referral of children needing follow-up services varies considerably. In addition, the lack of uniform national recommendations for reporting blood lead levels has created a burden on private laboratories and others that must report this information to many different states in a variety of formats, and has made it difficult to assess and compare blood lead data across states.

CDC should establish national standards for blood lead reporting to ensure standardization of blood lead data and enable timely follow-up for lead-poisoned children.

States with blood lead reporting systems should evaluate the effectiveness of their systems in triggering prompt identification and follow-up of lead-poisoned children and address any identified deficiencies.

States without a central reporting system for blood lead levels should establish one as soon as possible.

Blood lead levels at which services are provided

CDC's 1997 guidance recommends that both case management and environmental investigation be provided at blood lead levels of 20 μg/dL or persistent levels of 15–19 μg/dL. Encouragingly, most states are providing services to children at or even below the blood lead thresholds recommended by CDC. For environmental investigation, 20 states perform environmental investigation only at blood lead levels at or above 20 μg/dL (not persistent levels above 15 μg/dL) and 2 states use a trigger of 25 μg/dL. Since environmental investigation permits the identification and subsequent control of lead hazards, early hazard identification by providing environmental investigation at lower blood lead levels is a positive preventive measure.

Some states are able to vary the scope of case management services provided by blood lead level, providing less intensive services at lower blood lead levels in order to intervene before blood lead levels rise. Thus, it is not surprising that many states report offering case management at lower blood lead levels than recommended by CDC. Six states offer case management at precisely the level recommended by CDC, and 28 states offer the service at lower levels (single levels above 15 μg/dL or 10 μg/dL). Fourteen states provide case management only at blood lead levels of 20 μg/dL, but not persistent levels between 15 and 19 μg/dL as recommended by CDC.

At a minimum, states should provide case management and environmental investigation to children at the levels recommended by CDC, and, resources permitting, preventive services and environmental investigation to as many children as possible with blood lead elevations at or above 10 μg/dL.

KEY FINDINGS AND RECOMMENDATIONS ON SETTING STANDARDS FOR SERVICES

Case management standards

The lack of national standards for case management of lead-poisoned children has created variation in approach across the country, and made achieving reimbursement from Medicaid and other insurers more difficult. At present, only 29 state programs indicated they had written standards for case management. However, a consensus document Case Management for Childhood Lead Poisoning, developed by the National Center for Lead-Safe Housing, describing professional standards for case management for lead-poisoned children already serves as a guide for some state and local programs. Other complementary documents exist or are under development.

Any case management protocol or standard must include certain elements to ensure quality care. Our survey found that states performed well in some areas, but needed improvement in others. For example, although most states (43) provide home visits as part of case management, many programs make only a single home visit, which is unlikely to be sufficient for ensuring that steps are taken to improve the health status of the child. In addition, almost one-third (29%) of programs fail to inquire about a lead-poisoned child's WIC status, an important oversight given the importance of good nutrition for lead-poisoned children. Because they are an essential part of the solution, families should be systematically involved in all aspects of the case management process. Yet, our survey found that more than one-third of state programs (37%) fail to include families in the planning process and only one state program indicated that it routinely refers families to parent support groups in the community. The indefinite continuation of cases is also a sign of a weak case management, yet 14 states reported that they had no criteria for when to close a case.

Case management standards must also describe the specific interventions to improve the health status of the child that should be provided by case managers. Nearly all states provide some type of educational intervention, including education focused on lead and lead exposure risks, lead-specific cleaning practices, and nutritional counseling. Two-thirds of state programs (67%) provide assistance with referrals to other necessary services and 80% provide follow-up of identified problems. Six state programs indicate that they now refer young children routinely to Early Intervention programs for identification and treatment of possible developmental problems. Surprisingly, 10 states provide specialized cleaning services to reduce immediate lead dust hazards in homes as part of their case management interventions. However, due to funding considerations, most of these states are not able to make cleaning available except in homes in designated target areas and under special circumstances.

All states should have in place a protocol that identifies minimum standards for initiation, performance, and tracking of case management services for lead-poisoned children, including standards for data collection and outcome measurements and for professional staffing and oversight.

CDC or its Advisory Committee on Lead Poisoning Prevention should endorse a set of national standards for case management for lead-poisoned children, beginning with a definition of the term case management. The consensus standards developed by the National Center for Lead-Safe Housing (*Case Management for Childhood Lead Poisoning*) offer a thorough, current, and complete set of expert standards for quick review and endorsement.

Once national standards are in place, state protocols should be reviewed for consistency. In the interim, states should utilize written protocols specifying the services to be provided along with performance standards and record-keeping criteria.

Case management standards should include a minimum of two case management visits to the home of a lead-poisoned child.

State case management protocols should include standards for assessment, specifically including assessment of WIC status.

State programs should evaluate the extent to which families are being involved in case management and make necessary program modifications to ensure that families are fully involved in planning, implementation, and evaluation efforts.

States should examine their referral practices to ensure that parents of lead-poisoned children are routinely referred to available resources, including community-based parent support groups, where they exist, in order to connect families with another source of support and assistance.

All states should have case closure criteria that encompass reduction in a child's blood lead level and control of environmental lead hazards and procedures for administrative closure when needed.

States that routinely follow children until 6 years of age should evaluate whether such a lengthy follow-up benefits the child and family.

Case management standards should specify recommended interventions, including: basic educational interventions; referrals to Early Intervention services for developmental assessment, referral services for WIC, housing (emergency and long-term Solutions), health care, and transportation, as needed; follow-up of identified problems as needed; and, follow-up to ensure that families receive needed services.

Environmental investigation standards

State programs vary widely as to what activities constitute an environmental investigation to determine the source of lead exposure. Only 35 states have written protocols for environmental investigation. Where written protocols do exist, the scope of services and the kinds of data collected vary extensively. For example, some programs rely almost exclusively on XRF analysis to test the lead content of paint, and interpret a positive reading for the presence of lead-based paint as source identification. Other programs focus on current pathways of exposure by taking dust wipe and paint chip samples, assessing paint condition, and in some cases evaluating exposures from bare soil and drinking water. And, still other programs operate on a case-by-case basis.

Just 35 states had minimum requirements in place for those who perform environmental investigations for lead-poisoned children; most frequently they required state-certified risk assessors or lead inspectors. Training in the certified disciplines of risk assessor and lead inspector provides a core foundation of knowledge as well as credentials that may be important in any legal proceedings. At the same time, additional training beyond these certified disciplines is needed, because the scope of the environmental investigation of a lead-poisoned child is much more comprehensive than a standard residential lead inspection, and somewhat broader than a risk assessment.

The responses to our survey do not make it possible to determine the extent to which states are performing (or requiring to be performed) clearance testing after work has done to respond to lead hazards identified in the home of a lead-poisoned child. Follow-up visits are essential to ensure that corrective measures were taken and lead safety precautions followed. Because lead-contaminated dust can be invisible to the naked eye, clearance dust tests are critical to ensure the effectiveness and safety of the corrective measures in the vast majority of situations. Post-activity dust tests should be taken after completion of any paint repair or other projects that could generate lead-dust contamination.

Many program staff expressed frustration that environmental investigations frequently do not result in any corrective action. The ultimate measure of the success of an environmental investigation is the action that results to control lead hazards to reduce the child's continued lead exposure. At the extreme, conducting a full environmental investigation is irrelevant if no measures to reduce lead exposure occur as a consequence.

States should have a written protocol identifying the components of an environmental investigation for a lead-poisoned child. Appropriate flexibility and customization based on specific case factors and local sources are legitimate and important elements.

The protocol for environmental investigation should include routine collection of data on important pathways of exposure (particularly interior dust lead) and documentation of poor paint condition. The XRF analyzer should never be relied upon as the only tool for environmental investigation. Chapter 16 of HUD's Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing provides the most comprehensive and current guidance for environmental investigations.

State programs should begin using the more protective dust lead standards being proposed by EPA and HUD: no higher than 50 μg/square foot for floors and 250 μg/square foot for window sills.

Environmental investigations need to generate ''actionable'' data to ensure that all lead hazards identified are controlled—the ultimate measure of effectiveness. In most states, improved systems are needed to document and track corrective actions to control lead hazards to help ensure that environmental investigations actually result in health benefits to children.

Health department program staff performing an environmental investigation for a lead-poisoned child should be trained and certified as lead professionals. This will serve to increase professionalism in the field as well as give the results of the investigation greater standing if challenged in court.

Individuals conducting environmental investigations need additional training to assess sources of lead exposure beyond the scope of the traditional EPA/HUD risk assessment.

When state or local programs or managed care organizations contract environmental investigations out to certified lead evaluators, it is important that they be charged with conducting a comprehensive evaluation of potential exposure sources as described in Chapter 16 of HUD's Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing.

State programs need to make clearance dust tests a routine check to confirm that lead dust hazards are not left behind after corrective measures are taken in the home of a lead-poisoned child.

Lead hazard control: Legal authority and resources

Although this survey was not able to quantify the extent to which state and local programs succeed in controlling hazards identified in home of a lead-poisoned child, many programs indicated that this is a major problem. Twenty-eight states, more than 54%, do not have legal authority to order remediation of homes with identified lead hazards. More than 40% of all states (22 state programs) indicate that no funding is available in their state to help property owners pay for even a portion of the necessary lead hazard control. No state reported sufficient funds for lead hazard control. The lack of legal authority to order remediation coupled with the lack of resources to fund abatement and lead hazard control is a major stumbling block for lead poisoning prevention and treatment progress nationally.

States should consider the model legislative language reflecting the principles and recommended lead-safety standards of the National Task Force of Lead-Based Paint Hazard Reduction and Financing developed by the National Conference of State Legislatures.

KEY FINDINGS AND RECOMMENDATIONS ON FINANCING SERVICES

For both case management and environmental investigation, adequate funding for services is a central challenge to providing timely and quality services. Most programs have patched together funding from federal, state, and local sources as best they can. For case management, 23 states reported relying primarily on federal funds, 12 states rely primarily on state funds, and 4 states on Medicaid. Six states reported a combination of sources. Even in states with Medicaid reimbursement, Medicaid provides only part of the support for case management. For environmental investigation, CDC grant funds are the most common source of funds for environmental investigation, with 22 states reporting reliance on this funding source; some use CDC funds exclusively. Medicaid reimbursement is the next most common source of funding for environmental investigation, with 20 states receiving at least some reimbursement for services provided for Medicaid-enrolled children. State funds provide support in 17 states and local or county funds in 15 states. Other sources fill in the gaps.

However, it appears that financing is not the strongest area of state case management and environmental investigation programs. Many state program staffs are not aware of how their programs actually receive funds for case management and environmental investigation services, and others seemed to be confused about the concept of ''reimbursement'' for services. At least 6 states provided different answers to the GAO than they provided to us on the question of state Medicaid policy for reimbursement of environmental investigations. GAO surveyed EPSDT agencies while we surveyed program staff responsible for lead-related services, but both should be expected to be able to answer this question accurately.

Twenty states currently seek and receive Medicaid reimbursement for case management, and 22 states report Medicaid reimbursement for environmental investigation, (although apparently slightly fewer are actually collecting Medicaid dollars at this time). States using state (or local) funds for environmental investigation or case management without receiving Medicaid reimbursement are effectively forgoing the federal Medicaid match for state spending. By all rights, Medicaid should pay the costs of these medically necessary treatment services for enrolled children. In addition, by securing Medicaid reimbursement, states may be able to shift the state's share of costs to the Medicaid budget, rather than using the limited funds designated for lead poisoning prevention or other public health functions. Similarly, states that use CDC lead poisoning prevention grant funds for environmental investigation without securing Medicaid reimbursement should consider the opportunity costs. Since CDC grant funds are finite and scarce, the decision not to seek Medicaid reimbursement means forgoing other possible uses, such as initiatives targeted to primary prevention.

The amounts reimbursed by Medicaid for both services vary dramatically from state to state, ranging from $38 to $490 for environmental investigation and from $25 for one educational visit to a maximum of $1,610 for 8 months of follow-up for case management. Although the set of services provided varies to some extent state-by-state, the actual cost of providing the services is unlikely to vary so widely. Ideally, reimbursement should reflect the actual costs of service delivery. State and local programs cannot successfully bill Medicaid or managed care for services provided unless they can document the actual cost of providing those services.

States following HUD Guidance for investigating the home of a lead-poisoned child are likely to need to conduct a number of specific laboratory tests, possibly including interior dust wipes, paint chips, soil, and drinking water. Yet a vital source of funding for environmental investigation has recently been restricted. In September 1998, HCFA

erected a barrier to quality care when it ''clarified'' its policy on reimbursement for environmental investigation in its update to the State Medicaid Manual. HCFA's written policy now inappropriately prohibits reimbursement for the environmental sampling and analysis (such as measuring lead in dust, soil, and water) that is needed to investigate the source of lead exposure in a poisoned child's home—and makes it impossible to achieve the essential purpose of environmental investigation. In effect, the new language limits coverage only to XRF analysis to determine the lead content of paint, which usually does not confirm the immediate exposure hazard or reveal what control action is needed to reduce exposure.

Several states reported arbitrary limits on State Medicaid reimbursement for environmental investigation services, such as limiting payment to one investigation per child per lifetime. It appears that such limits on environmental investigation are illegal, since the federal EPSDT statute entitles Medicaid children to all services medically necessary to respond to a condition identified during an EPSDT screen.

Only one-third of states could report how many or what percentage of their cases were even enrolled in Medicaid. States must be able to document the number of Medicaid-enrolled children receiving services in order to receive or make informed decisions about reimbursement.

Thirty-eight states reported the enrollment of at least some Medicaid children into managed care plans, but only 24 of these reported that their state's contract(s) with managed care organizations (MCOs) contained any language about lead screening or treatment services. Most reported that the language dealt only with lead screening or generic EPSDT screening requirements, missing an opportunity to describe clear duties for health care providers for lead screening and follow-up care.

State Medicaid agencies that have not yet established mechanisms for Medicaid reimbursement for case management and environmental investigation should do so immediately.

Health departments providing case management and environmental investigation should contact the Medicaid agency to ensure that reimbursement is available to public sector service providers, customized for the specific situation.

CDC should require its CLPP grantees to pursue Medicaid reimbursement of case management and environmental investigation as a condition of funding.

HCFA should revise its guidance to permit Medicaid reimbursement for the costs of the laboratory samples necessary to determine the source of lead exposure in the home of a lead-poisoned child.

Medicaid should fund emergency services to reduce lead hazards for children with EBL, including lead dust removal and interim measures to immediately reduce hazards in the child's home. If the child's home can not be made safe, Medicaid should reimburse the cost of emergency relocation.

State programs should determine and document the actual costs of providing case management and environmental investigation services.

State lead programs should negotiate adequate reimbursement rates with the State Medicaid agency, based on documentation of the costs of providing services.

Based on current costs of service delivery, state and local programs should ensure that their budgets and funding requests seek the resources necessary to adequately manage their caseloads.

States should consider billing private insurance providers for services provided to children enrolled in such plans.

HCFA should disallow, and states should discontinue the use of, arbitrary limits on State Medicaid reimbursement for environmental investigation services unless they are shown to have a medical basis.

State programs should establish the administrative means necessary to track the insurance status (especially Medicaid enrollment) of lead-poisoned children receiving case management and environmental investigation services.

CDC should require its CLPP and Surveillance grantees to pursue collection of data on the insurance status (especially Medicaid enrollment) of the children receiving case management and environmental investigation services.

State Medicaid contracts with MCOs should contain clear language describing the specific duties of the MCOs, making clear whether they are expected to deliver services, make referrals, or provide reimbursement to other agencies for services provided. States should address lead screening, diagnosis, treatment, and follow-up services explicitly, rather than relying on general language referencing EPSDT. States should familiarize themselves with and utilize the lead purchasing specifications for Medicaid management care contracts that have been developed by the Center for Health Policy and Research at the George Washington University (available at ''www.gwumc.edu/chpr''). Where such language has already been incorporated into contracts, it should be enforced.

Where case management and environmental investigation are provided by public sector providers and Medicaid children are enrolled in capitated managed care plans, states should consider financing case management and environmental investigation through a ''carve-out'' to ensure that providers are reimbursed for their costs of providing services.

KEY FINDINGS AND RECOMMENDATIONS ON TRACKING AND EVALUATING SERVICES

Very few programs are tracking outcomes of children identified as lead poisoned. Most states count the number of home visits or completed environmental investigations, but very few monitor the outcomes for children and the corrective measures taken in those properties found to have poisoned a child. For example, eight states did not know how many lead-poisoned children needing follow-up care had been identified in 1997 and 23 states did not know how many of their lead-poisoned children had actually received services.

Only 15 states reported providing oversight to ensure that all children identified as lead-poisoned receive appropriate follow-up care, including case management and environmental investigation services. Such oversight would be particularly useful in the 24 states that rely on providers outside the health department to provide case management services. Only 13 states indicated that they collected and tabulated data on the identified source(s) of lead exposure from environmental investigations.

Tracking case management and environmental investigation activities is not enough in itself. The ultimate measure of effectiveness is reducing the child's lead exposure and blood lead level. Case management and environmental investigation programs should be thoroughly evaluated to identify programs that are effective, as well as to identify problems that require additional staff training, technical assistance, or other attention. In particular, this survey suggests that staff in many states could benefit from training in key areas, such as program evaluation and Medicaid and insurance reimbursement.

States should establish the administrative capacity at either the state or local level to track delivery of case management and environmental investigation services to lead-poisoned children, to track outcomes of interest for individual children, and to ensure that appropriate services are provided to lead-poisoned children.

CDC should require its CLPP grantee to report on case management service delivery outcome measures in their required reports. Such reporting would help build capacity for tracking and begin to document the effectiveness of program follow-up efforts.

States should establish, collect, and report outcome measures for case management.

All states should collect and aggregate data on lead sources, including the proximate cause(s) of lead exposure identified through environmental investigation, and the lead hazard control actions taken, along with relevant information allowing characterization of the lead hazards (e.g., age and condition of housing, renter or owner-occupied, source and pathway of exposure, etc.)

CDC requires its grantees to provide data through its STELLAR database, but its data fields have proven to be limiting, especially for non-paint sources, and many grantees report their dissatisfaction with STELLAR. CDC should consider moving to an alternative software package with greater flexibility and easily available support. Until CDC revises its requirements, states should use standard office database software to keep these records.

CDC should undertake or fund formal evaluations of state case management and environmental investigation programs. Programs should be given the tools and opportunity to meet goals and improve performance. However, if state or local programs are not able to achieve basic standards of performance in follow-up of lead-poisoned children, federal funding should be terminated.

CDC should sponsor a system of peer evaluation for state and local lead programs. A pear evaluation program would allow state program staff to learn from and share with one another, reinforcing the replication of innovative and effective practices.

The PRESIDING OFFICER (Mr. CRAIG). The Senator from Maine.

Ms. COLLINS. Mr. President, I am very pleased to join my friend and colleague, Senator JACK REED of Rhode Island, in discussing the passage of a resolution we introduced designating this week, October 24 through the 30th, as National Childhood Lead Poisoning Prevention Week.

Senator REED has been such a strong advocate and leader on lead poisoning issues. I have enjoyed working with him on this important public health issue.

It is my hope the designation of this week as National Childhood Lead Poisoning Prevention Week will help to increase awareness of the significant dangers and prevalence of childhood lead poisoning across our Nation.

Great strides have been made in the past 20 years to reduce the threat that lead poses to human health. Most notably, lead has been banned from many products, including residential paints, food cans, and gasoline. These commendable steps have significantly reduced the incidence of lead poisoning. But unfortunately, contrary to what many people think, the threat has not been eradicated. In fact, it remains and continues to imperil the health and well-being of our Nation's children. In

fact, lead poisoning is the No. 1 environmental health threat to children in the United States.

Even low levels of lead exposure can have serious developmental consequences, including reductions in IQ and attention span, reading and learning disabilities, hyperactivity and behavioral problems. The Centers for Disease Control and Prevention currently estimates that 890,000 children, age 1 through 5, have blood levels of lead that are high enough to affect their ability to learn—nearly a million children.

Today, the major lead poisoning threat to children is posed by paint that has deteriorated. Contrary to popular belief, it is the dust from deteriorating or disturbed paint, rather than paint chips, that is the primary source of lead poisoning. Unfortunately, it is all too common for older homes to contain lead-based paint, particularly if they were built before 1978. More than half of the entire housing stock and three-quarters of homes built before 1978, contain some lead-based paint. Paint manufactured prior to the residential lead paint ban often remains safely contained and unexposed for decades. But over time, often through remodeling or normal wear and tear, the paint can become exposed, contaminating the home with dangerous lead dust.

The PRESIDING OFFICER. The Senator from Virginia is recognized.

PRESIDENTIAL AND SENATORIAL COMMISSION ON NUCLEAR TESTING TREATY

Mr. WARNER. Mr. President, I address the Senate today with regard to a bill that I am introducing which provides for the establishment of a commission to be known as the Presidential and Senatorial Commission on a Nuclear Testing Treaty.

On October 15, shortly after the historic debate in the Senate and the vote taken on the Comprehensive Test Ban Treaty, I addressed the Senate, suggesting that the President and the Senate explore options by which a commission could be appointed for the purpose of assessing issues relating to testing of nuclear weapons, and the possibility of crafting a treaty that would meet the security interests of our Nation, while enabling America to once again resume the lead in arms control.

Following the historic debate and vote, I voted against that treaty, and I would vote again tomorrow against that treaty, and the day after, and the day after that. I say that not in any defiant way, but simply, after three hearings of the Armed Services Committee and one of the Foreign Relations Committee, after very careful analysis, after hours of discussion with my colleagues, after participating in the debate, it was clear to me that the record did not exist to gain my support nor, indeed, the support of two-thirds majority of the Senate.

It is my view that the Senate and the President will join together to provide bipartisan leadership to determine, in a collaborative way, how to dispel much of the confusion in the world about why this Senate failed to ratify the treaty, to explain what the options are now, and to show that we are analyzing all of the other possibilities relating to a nuclear testing treaty. This, hopefully, will dispel such confusion. Much of that confusion is based on misconceptions and wrong information. But we can overcome that.

We must explain that this Government has coequal branches—the executive, headed by the President; and the legislative, represented by the Congress—and how our Constitution entrusts to this body, the Senate, sole authority to give advice and consent. This body exercised that obligation, I think, in a fair and objective manner. But we are where we are.

My bill is somewhat unique, Mr. President. I call for a commission with a total of 12 members—6 to be appointed by the majority leader of the Senate; 6 to be appointed by the distinguished Democratic leader of the Senate, with coequal responsibility between two members to be designated as cochairmen. I did that purposely to emphasize the need for bipartisanship. We, the Senate, will not ratify the treaty unless there are 67 votes in the affirmative. This last vote was 19 votes short—votes cast by individuals of this body of clear conscience. That significant margin of 19 votes, in my judgment, can only be overcome through a bipartisan effort to devise a nuclear testing treaty seen clearly as in our national interests.

The cochairmen will be appointed—first, one by the distinguished majority leader of the Senate, and the second by the President, in consultation, of course, with the distinguished minority leader. That brings the President well into the equation. He will undoubtedly be in consultation with the distinguished minority leader throughout the series of appointments by the minority leader.

This commission can have no more than two Members of the Senate appointed by the majority leader, and no more than two Members of the Senate, if he so desires, appointed by the minority leader. Therefore, up to four Senators could participate. But the balance of the 12—eight members—will be drawn from individuals who have spent perhaps as much as a lifetime examining the complexity of issues surrounding nuclear weapons, the complexity of the issues surrounding all types of treaties, agreements, and understandings relating to nonproliferation.

We saw them come forward in this debate—individuals such as former Secretaries of Defense, former Secretaries of State, men and women of honest, good intention, with honest differences of opinion, and those differences have to be bridged. By including eight individuals not in the Senate along with four Senators—if it is the will of the leaders—we can lift this issue out of the cauldron of politics. We can show the world that we are making a conscientious effort to act in a bipartisan manner. The experts the majority leader and the ones the minority leader, in consultation with the President, would pick will be known to the world—former Secretaries of Defense of this Nation, former Secretaries of State, former National Laboratory Directors, individuals whose collective experience in this would add up to hundreds of years. In that way, I believe we will bring credibility to this process and will result in this commission being able to render valuable advice and recommendations to the Senate and the President at the end of their work.

Several years ago, I was privileged to be the Ranking Member of the Senate Select Committee on Intelligence. There was a great deal of concern in the Senate toward the Central Intelligence Agency and how it was operating at that time. As a matter of fact, some of our most distinguished Members—one indeed I remember clearly—called for the abolishment of the CIA. This individual was extremely disturbed with the manner in which they were conducting business.

I took it upon myself at that time to introduce in the Senate legislation calling for the establishment of a commission to make an overall study of our intelligence and to make recommendations to the President and the Congress. Congress adopted the legislation I introduced and it was enacted into law.

The first chairman of that commission was Les Aspin, former Secretary of Defense, who, unfortunately, had an untimely death. He was succeeded by Harold Brown, former Secretary of Defense and former Secretary of the Air Force, who I knew well. I served with him. Our former colleague, Senator Rudman, was also closely involved. I was privileged to be on that commission. It did its work. It came up with recommendations. The intelligence community accepted those recommendations. The CIA survived and today flourishes.

I have given the outline of the commission I am proposing today. Let me briefly refer to the basic charge given the commission and the work they should perform.

Duties of the commission: It shall be the duty of the commission, (1) to determine under what circumstances the nuclear testing treaty would be in the national security interests of our Nation; (2) to determine how a nuclear testing treaty would relate to the security interests of other nations. I was motivated to do this because of the misunderstanding about the important and decisive action taken by this body.

(3) To determine provisions essential to a nuclear testing treaty such that that treaty would be in the national security interests of the United States;