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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

VIRLA SPENCER, individually and on behalf of her minor children C.S., L.S., J.S., A.S., and M.S., and on behalf of a class of similarly situated individuals, Plaintiff, vs. WASHINGTON STATE HEALTH CARE AUTHORITY, an agency of the State of Washington; JAY INSLEE, in his official capacity as Governor of the State of Washington; DOROTHY TEETER, in her official capacity as the Director of the Washington State Health Care Authority; and MARYANNE LINDEBLAD, in her official capacity as the Medicaid Director of the Washington State Health Care Authority, Defendants.	Case No.: COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF (Pursuant to 42 U.S.C. § 1983 and the Medicaid Act, 42 U.S.C. § 1396 et seq.)

INTRODUCTION

1. This is a civil class action brought pursuant to the Civil Rights Act of 1871, 42 U.S.C. § 1983. Plaintiff alleges that the Washington State Health Care Authority has failed to provide or require universal blood lead testing for Medicaid-eligible children in violation of

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Section XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, more commonly known as the Medicaid Act. This case is brought on behalf of thousands of children throughout Washington who depend on defendants Washington Health Care Authority, Governor Jay Inslee, Dorothy Teeter, and Maryanne Lindeblad for screening, diagnostic, and treatment services to detect and treat lead poisoning.

2. By failing to provide or require universal blood lead testing for Medicaid-eligible children, defendants have deprived plaintiff's children of rights secured by the laws of the United States. In particular, they have deprived plaintiff's children of rights secured under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") program, and the implementing regulations and requirements of the Centers for Medicare and Medicaid Services.

3. The relief requested is necessary to prevent irreparable injury and plaintiff has no adequate remedy at law.

JURISDICTION, VENUE, AND BASIS FOR RELIEF

4. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 (federal question).

5. Venue is proper in the Western District of Washington pursuant to 28 U.S.C. § 1391(b) because defendants reside in and maintain offices in this district. A substantial portion of the events and omissions giving rise to the claims also occurred in this district. This complaint is properly filed at the Seattle Courthouse pursuant to CR 5(e)(1).

6. Declaratory relief is appropriate under 28 U.S.C. § 2201. Injunctive relief is appropriate under 28 U.S.C. § 2202 and 42 U.S.C. § 1983.

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PARTIES

7. Plaintiff VIRLA SPENCER is the parent of five minor children who reside in the State of Washington and who are eligible for Medicaid services. The minor children C.S., L.S., J.S., A.S., and M.S. have never been tested for lead toxicity as required by the Federal Medicaid Act and the EPSDT program. Ms. Spencer reasonably fears that without such testing, her children are at risk of lead toxicity and elevated blood lead levels. Ms. Spencer has requested that her children's medical providers perform the necessary lead toxicity screening as required by Medicaid and the EPSDT program, but that service has been denied. Ms. Spencer brings this lawsuit on behalf of her minor children to secure their right to early and periodic lead toxicity screening as required by the Medicaid Act and EPSDT program.

8. Pursuant to chapter 41.05 RCW and WAC 74.09, defendant WASHINGTON STATE HEALTH CARE AUTHORITY is the agency within the State of Washington responsible for administering the Medicaid Act.

9. Defendant JAY INSLEE is the Governor of the State of Washington. Governor Inslee is responsible for overseeing the Washington State Health Care Authority and is sued in his official capacity.

10. Defendant DOROTHY TEETER is the Director of the Washington State Health Care Authority, and is sued in her official capacity.

11. Defendant MARYANNE LINDEBLAD is the Medicaid Director of the Washington State Health Care Authority, and is sued in her official capacity.

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CLASS ACTION ALLEGATIONS

12. Plaintiff brings this action on behalf of a statewide class of children residing in the State of Washington who were eligible, are eligible, or will be eligible for the EPSDT program and who have not received blood lead testing as required under the EPSDT program.

13. The class is so numerous that it would be impracticable to join all members of the class. In 2011 alone, there were more than 140,000 Medicaid-eligible children in the State of Washington between the ages of zero and two years old.[1] These children and their parents are geographically dispersed, they have limited financial resources, and they are unlikely to institute individual actions.

14. There are issues of fact common to all members of the class. These facts relate to the lack of lead screening, testing, and treatment services under the EPSDT program. There are also issues of law common to all members of the class for deprivation of services required by the Medicaid Act.

15. The claims of the named plaintiff are typical of the claims of the class in that both the named plaintiff and class members have the right to be informed about and to receive lead screening, testing, and treatment services under the EPSDT program.

16. The named plaintiff and counsel will fairly and adequately protect the interests of the class they represent. The named plaintiff has no interest adverse to or in conflict with those of other class members.

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[1] Letter from Chandra Moss, Operations Manager of State of Washington Department of Social & Health Services, to Cindy Ruff, Centers for Medicare & Medicaid Services, re: Submission of Annual 416 Report for State of Washington (June 22, 2011).

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1 17. The defendants have refused to act on grounds generally applicable to the whole
2 class, making injunctive and declaratory relief appropriate in a single action.

3 **LEGAL BACKGROUND**

4 18. The Medicaid Act provides for federal financial assistance to states, enabling
5 states to provide medical care to needy individuals and children. At the federal level, Medicaid is
6 administered by the Secretary of Health and Human Services, who has delegated her authority to
7 the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing
8 Administration). Acting under the Medicaid Act, the Secretary has published regulations binding
9 on all states choosing to participate in the Medicaid program.
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11 19. The Secretary, acting through the Centers for Medicare and Medicaid, has also
12 published a State Medicaid Manual. The State Medicaid Manual "is an official medium by which
13 [the Centers for Medicare and Medicaid] . . . issues mandatory, advisory, and optional Medicaid
14 policies and procedures to the Medicaid State Agencies." State Medicaid Manual, Forward at i
15 (hereinafter "Manual"). Instructions in the Manual are "official interpretations of the law and
16 regulations, and, as such, are binding on Medicaid State Agencies." *Id.*
17
18 20. States are not required to participate in Medicaid. But if they do, they are obligated
19 to comply with the Medicaid Act and the regulations of the Secretary of Health and Human
20 Services. Washington has elected to participate in Medicaid and is, therefore, bound by the
21 Medicaid Act and its regulations, as well as the State Medicaid Manual.
22
23 21. To receive funding under Medicaid, a state must adopt a state plan for medical
24 assistance and the Secretary must approve the plan. 42 U.S.C. §§ 1396-1(2), 1396b(a). The state
25 plan is a contract between the federal government and the state that sets forth the terms necessary
26 to implement and comply with the Medicaid Act and regulations. However, even if a state has an

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approved plan that conforms to the Medicaid Act, the state may still violate the Act in practice by failing to provide services required by the Act or its implementing regulations.

22. One of the core programs in the Medicaid Act is the EPSDT program, under which each state must make available minimum screening and diagnostic services to Medicaid-eligible children. *See* 42 U.S.C. § 1396a(a)(10)(A). These minimum screening and diagnostic services include a comprehensive health and developmental history, a comprehensive physical exam, appropriate immunizations, health education, and "laboratory tests (including lead blood level assessment appropriate for age and risk factors)." *Id.* at § 1396d(r)(1)(B)(iv).

23. If an illness is discovered during the EPSDT screening procedures, the state must provide treatment even if the treatment would not otherwise be covered. *Id.* at §§ 1396a(a)(43)(C), 1396d(r)(5). For this reason, the EPSDT screening procedures are a critical first step to ensuring that all childhood illness is diagnosed and treated in a timely manner.

24. In addition to making these EPSDT services available, including blood lead testing, every state plan must provide for "informing all [Medicaid-eligible] persons in the State who are under the age of 21 . . . of the availability of early and periodic screening, diagnostic, and treatment services as described" above. 42 U.S.C. § 1396a(a)(43)(A). If an individual requests EPSDT services, then the state must provide the screening services enumerated at 42 U.S.C. § 1396d(r), including blood lead testing appropriate to the individual's age and risk factors. *See* 42 U.S.C. § 1396d(r)(1)(B)(iv); 42 C.F.R. § 441.56(b); Manual at § 5122(A). The individuals who must be "informed" of EPSDT services include "Medicaid-eligible families" and "newly eligible families, either determined eligible for the first time, or determined eligible after a period of ineligibility if they have not used EPSDT services for at least 1 year." Manual at § 5121(B). If a family has been going on and off the rolls, they must be informed at least once a year. *Id.*

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Medicaid-eligible pregnant women must also be informed of EPSDT services for their children. *Id.*

25. In its State Medicaid Manual, the Centers for Medicare and Medicaid Services have clarified when blood lead testing must be performed, and for whom. The Manual explains that because "[a]ll children are considered at risk," all Medicaid-eligible children "*must* be screened for lead poisoning." Manual at § 5123.1 ("Minimum Standards and Requirements") (emphasis in original). All Medicaid-eligible children must have their blood lead levels checked at 12 and 24 months of age. *Id.* Children between the ages of 36 and 72 months of age must also receive a blood lead test if they have not previously been tested. *Id.*

26. The Manual expressly provides that the decision to test a child's blood lead level may not be left to the discretion of individual physicians. *Id.* ("*With the exception of lead toxicity screening*, physicians providing screening services under the EPSDT program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed") (emphasis added). "States may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children." *Id.*

27. The Centers' universal blood lead testing policy has been in place since 1993, when, pursuant to a federal consent decree, the Centers agreed to require blood lead testing for all Medicaid eligible children. Recently, the Centers adopted a narrow exception to this rule. The Centers now "recommends a targeted screening approach for children eligible for Medicaid," but only "in States where data exists to support discontinuing universal screening of all Medicaid

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1 eligible individuals."[2] Under the new "targeted" screening policy, states must obtain the Centers' 2 approval before shifting to a targeted screening program, and "[f]or states that do not have 3 sufficient data to allow targeted lead screening for Medicaid eligible children, the universal 4 screening requirement for Medicaid eligible children ages 1 and 2 will remain in effect."[3]
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6 28. To date, Washington has not requested permission to transition to a targeted blood 7 lead screening program nor submitted information to the Centers showing that a targeted plan 8 would be appropriate in Washington. Washington is, therefore, required under the Medicaid Act, 9 the Act's implementing regulations, and the State Medicaid Manual to provide blood lead testing 10 to all Medicaid-eligible children.
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12 **FACTUAL BACKGROUND**

13 **Lead Contamination in Washington**

14 29. According to the United States Environmental Protection Agency, lead poisoning 15 is "the number one environmental health threat to children ages six and younger in the U.S."[4] In 16 2009, the Washington Department of Ecology and the Washington Department of Health 17 produced a Chemical Action Plan for lead, concluding that "there is no known safe level of lead, 18 and despite several national efforts in the past century to reduce people's exposure, it is still a 19 hazard for people and the environment in Washington."[5] To date, the Action Plan constitutes the
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22 [2] CMS, Guide for States Interested in Transitioning to Targeted Blood Lead Screening for Medicaid-Eligible Children, May 2012, at 1. *Available at* http://www.medicaid.gov /Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/TargetedLeadScreening.pdf.

23 [3] CMCS Informational Bulletin: Targeted Lead Screening Plans, June 22, 2012, at 1. 24 *Available at* http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-22-12.pdf.

25 [4] *See* http://yosemite.epa.gov/opa/admpress.nsf/0/5E312CBE6666DCA8852579340068EBEF.

[5] Washington Departments of Ecology and Health, Washington State Lead Chemical 26 Action Plan (September 2009) (hereinafter "Action Plan"). The purpose of a chemical action plan is to assess problems and recommend actions to reduce threats caused by the use of persistent,

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most current and comprehensive study of lead contamination and lead-related health impacts in the State of Washington. The following are some of its key findings:

30. Children are especially vulnerable to lead poisoning. Everyone is exposed to lead and everyone may be harmed by lead contamination. But children face a heightened risk of lead poisoning due to their natural hand-to-mouth behavior. Traditionally, lead-based paint in older homes has been the greatest source of lead contamination in children, either by the direct ingestion of paint chips or the ingestion of lead-contaminated dust.

31. Children in Washington are also exposed to lead through drinking water and soils contaminated by lead arsenate pesticides, exhaust fumes from leaded gasoline, and particulate emissions from smelters.[6] Many of these sources of lead contamination are now banned. But lead persists in the environment and remains close to the surface of topsoil long after the source of contamination has ceased. Soils along roads, near old smelters, and in old orchards may still contain harmful levels of lead and pose a risk to children playing there.

32. Even small exposures to lead can have negative health effects. Blood lead levels equal to or greater than 2 µg/dL (equal to less than 20 grains of salt) cause decreased IQ, attention deficits, reduced reaction time, and interfere with fine motor skills. As of 2007, approximately 19.96 percent of children in Washington who were tested had blood lead levels at or above 2 µg/dL, which is just above the average blood level among all children tested that year. These

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bioaccumulative, and toxic chemicals and metals of concern. These chemicals and metals, including lead, are considered "the worst of the worst" because they persist in the environment for a long time, they build up in the bodies of humans and animals, and they can be harmful in very small amounts.

[6] The Department of Ecology has identified approximately 489,000 acres of land across Washington contaminated by historic smelters, and 188,000 acres of land contaminated by lead arsenate pesticides. These numbers are in addition to "unknown and highly variable levels of lead in soil next to roadways, due to historic use of leaded gasoline." Action Plan at 14.

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effects are amplified at higher levels of exposure, and are associated with increased aggression and abnormal social behavior, abnormal growth patterns and development, and anemia. In 2007, 3.22 percent of children tested in Washington had blood lead levels above 5 µg/dL, the "action level" recommended by the Centers for Disease Control and Prevention.

33. Some of these health impacts are often expressed at a subclinical level, meaning the effects are "generally too small to be easily noticed in a routine medical examination." *Id.* at 20.

34. Medicaid-eligible children face a heightened risk of lead poisoning in comparison to other children. Studies have consistently demonstrated that Medicaid-eligible children face a higher risk of lead poisoning when compared to other children. The Centers for Disease Control and Prevention have found that as many as 83 percent of young children in America with blood lead levels exceeding 20 µg/dL are eligible for Medicaid.[7] Other risk factors include young age, being of African American or Hispanic descent, living in a home built prior to 1950, and low income. These risk factors are consistently associated with blood lead levels above 10 µg/dL, well above the threshold for many lead-related health impacts.

35. Washington ranks high in terms of risk factors for lead poisoning. According to the Action Plan, "[c]ompared to the other 49 states, Washington has a relatively large number of young children with risk factors for lead poisoning." Action Plan at 17. As of 2009, Washington

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[7] *See* Managing Elevated Blood Lead Levels Among Young Children: Recommendations From the Advisory Committee on Childhood Lead Poisoning Prevention, March 2002, at 5. *Available at* http://www.cdc.gov/nceh/lead/CaseManagement/chap1.pdf.

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ranked 17th in number homes built prior to 1950,[8] 13th in number of Hispanics, 27th in number of African Americans, 18th in number of families with incomes below the poverty level, and 12th in number of children enrolled in Medicaid.

36. Lead contamination in Washington is not well understood. Relatively few children in Washington are ever tested for lead poisoning, despite that under federal law *all* Medicaid-eligible children are required to be tested. There is little to no data that indicate which children in Washington are tested. For example, it is plausible that many of the children who are tested come from low-risk backgrounds and from more affluent parents who deliberately request lead testing because they are aware of the problem. Thus, even if publically available data on the rate of lead poisoning in Washington is correct, it is likely that "few children in Washington with lead poisoning are found." Action Plan at 35.

37. The most recent information from the Centers for Disease Control and Prevention indicate that in 2012 only three percent of the State's 526,207 children under the age of six were tested for lead poisoning. *See* CDC National Surveillance Data at http://www.cdc.gov/nceh/lead/data/Website_StateConfirmedByYear_1997_2013_10162014.htm. Of those three percent (17,710 individuals), 461 children had blood lead levels above the current action level of 5µg/dL. Assuming the level of lead poisoning is representative of the entire child population in Washington, more than 14,000 cases of lead poisoning went undetected.

[8] According to the Action Plan and federal sources, of approximately 2,500,000 homes and apartments that existed in Washington in 2009, almost 1,500,000 were built prior to 1978 and about 700,000 were built prior to 1960. Action Plan at 25.

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Washington's Failure to Enforce Universal Blood Lead Testing

38. To plaintiff's knowledge and belief, the State of Washington has never enforced the Medicaid Act's universal blood lead screening requirement. Instead, Washington has left the decision to require blood lead testing to the discretion of individual physicians, who may not detect many of the negative side-effects of lead poisoning because the effects are consistent with a number of other causes, or because the effects are present at a subclinical level.

39. Washington's failure to enforce the universal blood lead screening requirement is apparent from the following facts:

40. In 2001, the National Conference of State Legislatures produced a report entitled "Lead Screening for Children Enrolled in Medicaid: State Approaches." As part of that report, the Conference surveyed the 50 states to determine how the states ensure that providers comply with the federal EPSDT screening requirements. Under the heading "Who Ensures that Providers Are Complying with Screening Regulations?" the entry for Washington reads "No one."

41. In 2006, the Centers for Medicare and Medicaid Services performed an on-site audit of Washington's Medicaid Program. The audit resulted in a letter from the Centers to the Washington Department of Social and Health Services explaining that the State "does not conform to the blood lead toxicity element of the screening component [of the Medicaid Act] and[,] therefore, is out of compliance with the EPSDT screening requirement."

42. To plaintiff's knowledge, the State did not make any changes to its blood lead screening policy in response to the 2006 audit. Instead, in a letter dated February 26, 2007, Robin Arnold-Williams, then Secretary of the Department of Social and Health Services, informed the Centers for Medicare and Medicaid Services that, in Ms. Arnold-Williams' opinion, a study performed in 1999 by the Washington Department of Health demonstrates that the incidence of

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lead poisoning in Washington is lower than the national average, and, therefore, universal lead screening is not needed in Washington. However, on March 28, 2007 the author of the Department of Health study, Eric Ossiander, wrote an email stating that while the study reflects the general incidence of lead poisoning in Washington, "we have less knowledge about any number of sub-populations in the state, such as inner city children, Medicaid children, etc."[9]

43. According to a June 8, 2007 letter from Maxine Hayes, then State Health Officer, to defendant MaryAnne Lindeblad, then Director of the Department of Social and Health Services, Division of Healthcare Services, "Washington does not have a universal blood lead screening policy."

44. A June 29, 2007 letter from defendant MaryAnne Lindeblad to plaintiff's counsel reports that "Washington State DOH does not recommend universal screening of asymptomatic children" and, as such, Washington will not enforce the universal screening requirement under the federal Medicaid Act.

45. In 2008, Representatives Hudgins, Hasegawa, and Roberts sponsored a bill in the Washington House of Representatives that would have required universal blood lead screening for all Medicaid-eligible children, in accordance with the Medicaid Act. *See* HB 3059, 60th Leg., Reg. Sess. (2008). On February 18, 2008, the bill passed the House with a vote of 95 in favor, zero opposed. But the Senate never calendared the bill for a floor vote.

46. On April 1, 2008, then Governor Gregoire vetoed section 209(29) of Engrossed House Bill 2687 (HB 2687, 60th Leg., Reg. Sess. (2008)). Section 209(29) of that bill would have

[9] *See* Email from Eric Ossiander, Department of Health, to Sharon Reddick, Department of Social and Health Services, Re: Lead Screening & our follow-up with CMS (March 28, 2007 at 2:10 pm) (on file with plaintiff's counsel).

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provided funding to the Washington Department of Social and Health Services to provide lead blood level assessments for any Medicaid-eligible child "in accordance with early and periodic screening diagnostic treatment services as defined in section 1905 of Title XIX of the federal social security act and its implementing regulations and guidelines."

47. Since at least 2007 and under the heading "Lead Toxicity Screening," the State's Medicaid Provider Guide has provided the following: "[h]ealth care providers should use clinical judgment when screening for lead toxicity." Washington State Health Care Authority, Medicaid Provider Guide: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program at 23 (April 1, 2015).[10] Neither the Medicaid Provider Guide, nor the state plan for medical assistance, requires universal lead testing for all Medicaid-eligible children.

48. Each year, Medicaid-participating states must submit reports to the Centers for Medicare and Medicaid Services on the number of children eligible for, and receiving, EPSDT services. Washington's reports for the years 2008 through 2013 show that, on average, four percent of Medicaid-eligible children between the ages of zero and two received blood lead screenings. In 2013, the year when the greatest number of lead screenings was performed, only six percent of Medicaid-eligible children between the ages of zero and two were screened.

49. To date, Washington has not submitted evidence to the Centers for Medicare and Medicaid Services demonstrating that a targeted lead screening plan would be appropriate for Washington. Nor has Washington developed a targeted screening program. Defendants and the State of Washington continue to operate the state Medicaid program in violation of federal law by not requiring universal blood lead testing of all Medicaid-eligible children.

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[10] Available at http://hrsa.dshs.wa.gov/billing/documents/guides/epsdt_bi.pdf.

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CLAIM FOR RELIEF

Failure to Provide Universal Blood Lead Testing to Medicaid-Eligible Children

(Pursuant to 42 U.S.C. § 1983 and the Medicaid Act)

50. Under the Medicaid Act, the Act's implementing regulations, and the State Medicaid Manual, the State of Washington is required to provide and require universal blood lead testing for all Medicaid-eligible children. Blood lead testing is required to take place at 12 and 24 months of age, and children aged six years or younger are required to be tested if they have not already. The State is also required to adopt a state plan for medical assistance that requires universal blood lead testing for all Medicaid-eligible children.

51. As of March 30, 2012, the Centers for Medicare and Medicaid Services allow a state to forego universal testing for all Medicaid-eligible children if the state submits data showing that universal testing is not needed, and only if the Centers approve a state plan for targeted testing.

52. The State of Washington, acting through defendants Washington Health Care Authority, Governor Jay Inslee, Dorothy Teeter, and MaryAnne Lindeblad, have failed to provide universal blood lead testing to Medicaid-eligible children, in violation of the Medicaid Act and federal law. The State has also failed to adopt a state plan for medical assistance requiring universal testing of all Medicaid-eligible children.

53. Defendants have not submitted data to the Centers for Medicare and Medicaid Services establishing that universal testing is not needed in the State of Washington, and the Centers have not approved an alternative, targeted testing plan. The defendants, therefore, are still bound by federal law requiring universal blood lead testing.

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54. By failing to require universal blood lead testing as required by federal law, and by failing to adopt a state plan for medical assistance requiring universal testing, defendants have deprived plaintiff and her children and the class that they represent of rights secured by the laws of the United States within the meaning of 42 U.S.C. § 1983.

PRAYER FOR RELIEF

WHEREFORE, plaintiff prays for the following relief:

1. Certification of the case as a class action under Rule 23(b)(2) and (3) of the Federal Rules of Civil Procedure;

2. A declaratory ruling that defendants have violated the requirements of the Medicaid Act, the Act's implementing regulations, and the State Medicaid Manual;

3. Injunctive relief requiring defendants to provide and/or require universal blood lead testing among Medicaid-eligible children;

4. An award for all reasonable costs and attorney's fees incurred in connection with this lawsuit, pursuant to 42 U.S.C. § 1988 and any other applicable law; and

5. Such further relief as this Court deems just and equitable.

DATED this 14th day of April, 2015.

Respectfully submitted,

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