GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

August 10, 2017

Ms. Anne Schuchat, M.D.
Acting Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027

Dear Ms. Schuchat:

We are writing to request additional information on the Centers for Disease Control and Prevention's (CDC) Childhood Lead Poisoning Prevention Program. We wrote to CDC on February 17, 2016 regarding the ongoing public health crisis in Flint, Michigan, and received a response on March 14, 2016. A copy of that letter is attached. We are now requesting an update on the Childhood Lead Poisoning Prevention Program, CDC's role in the Flint response, and our federal investment in lead poisoning prevention and surveillance.

Since CDC's March 2016 response to our letter, our concerns about the Flint water crisis have only grown. Although it has been three years since the crisis began, the city has estimated it will still be another two years before it can recommend that residents drink tap water without using filters.[1] Furthermore, multiple criminal charges and civil lawsuits have been filed, including charges of involuntary manslaughter brought by Michigan Attorney General Bill Schuette against five officials in connection with the deaths of Flint-area residents from Legionnaires' disease during the water crisis.[2]

In addition to Flint, a number of other cities reportedly have unsafe levels of lead in their drinking water. A Reuters investigation found "nearly 3,000 areas with recently recorded lead

---

[1] *Flint: 'All clear' for drinking water years away*, Detroit News (Mar. 7, 2017).

[2] *Schuette: Firms made Flint's water crisis 'worse'*, Detroit News (June 22, 2016); *Six More Officials Charged in Flint Water Crisis for Alleged Cover-Up*, NBC News (July 29, 2016); State of Michigan Attorney General Bill Schuette, *Schuette Charges MDHHS Director Lyon, Four Others with Involuntary Manslaughter in Flint Water Crisis* (June 14, 2017) (press release).

poisoning rates at least double those in Flint during the peak of that city's contamination crisis."[3] As CDC points out, the danger of blood lead levels in children is a nationwide concern:

> Today at least 4 million households have children living in them that are being exposed to high levels of lead. There are approximately half a million U.S. children ages 1-5 with blood lead levels above 5 micrograms per deciliter (μg/dL), the reference level at which CDC recommends public health actions be initiated. No safe blood lead level in children has been identified.[4]

CDC's Childhood Lead Poisoning Prevention Program provides funding to states to develop lead poisoning prevention programs, build surveillance capacity, and ensure that poisoned children receive appropriate health care services.[5] However, as we noted in our previous letter, funding for the Childhood Lead Poisoning Prevention program has fallen in recent years, from nearly $35 million in Fiscal Year (FY) 2010 to $17 million in FY 2016.[6] In FY 2017, the Childhood Lead Poisoning Prevention program received a one-time appropriation of $15 million as part of our response to the Flint water crisis, in addition to the $17 million it received through the annual appropriations process.[7]

While the program receives $17 million in annual appropriations from the Prevention and Public Health Fund,[8] both the House and Senate versions of Trumpcare would have eliminated this fund.[9] Moreover, President Trump's budget proposal threatens to cut CDC's budget by over

---

[3] *The thousands of U.S. locales where lead poisoning is worse than in Flint*, Reuters (Dec. 19, 2016).

[4] Centers for Disease Control and Prevention, *Lead* (www.cdc.gov/nceh/lead/) (accessed June 29, 2017).

[5] Centers for Disease Control and Prevention, *CDC's Childhood Lead Poisoning Prevention Program* (www.cdc.gov/nceh/lead/about/program.htm) (accessed June 29, 2017).

[6] Centers for Disease Control and Prevention, *Fiscal Year 2011: Justification for Estimates for Appropriation Committees* (www.cdc.gov/budget/documents/fy2011/fy-2011-cdc-congressional-justification.pdf) (accessed June 29, 2017); Centers for Disease Control and Prevention, *Fiscal Year 2018: Justification for Estimates for Appropriation Committees* (www.cdc.gov/budget/documents/fy2018/fy-2018-cdc-congressional-justification.pdf) (accessed June 29, 2017).

[7] Pub. L. 115-31; Pub. L. 114-254.

[8] U.S. Department of Health and Human Services, *Prevention and Public Health Fund* (www.hhs.gov/open/prevention/index.html) (accessed June 29, 2017).

[9] *Obamacare repeal guts crucial public health funds*, Washington Post (Mar. 8, 2017); *Senate GOP bill would gut critical public health funding this fall*, Washington Post (June 23, 2017).

$1.2 billion.[10] Therefore, we are increasingly concerned about whether CDC has the necessary resources to address this ongoing public health challenge.

In light of these concerns, we request the following information and answers to the following questions by August 30, 2017:

1. In its March 2016 response to our letter, CDC stated that "State and local health officials are coordinating with health care providers and others to implement" CDC's recommendations for blood lead testing and follow-up services for children in Flint. Please provide an update on the implementation of these recommendations.

2. In 2012, CDC defined a reference level of 5 µg/dL to identify children with elevated blood lead levels. However, in its response to our letter, CDC stated that "not all states have adopted CDC's most recent reference level for intervention of [greater than or equal to] 5 µg/dL, established in January 2012." Please provide us with an update on which states have adopted CDC's most recent reference level, and what CDC is doing to encourage all states to use the appropriate reference level as a threshold for intervention and follow-up services for children with lead poisoning.

3. Unsafe levels of lead in drinking water have been recorded in many cities beyond Flint. However, in CDC's March 2016 letter to the Committee, the agency stated: "At this time, CDC is not considering issuing similar city-wide site specific recommendations to other states, cities, or municipalities." Has CDC reconsidered its decision not to issue similar recommendations regarding lead testing and services for children in other locations beyond Flint?

4. CDC could face an almost 30 percent budget cut if President Trump's budget proposal is enacted and Congressional Republicans eliminate the Prevention and Public Health Fund. That cut would include the $17 million annual appropriation from the Childhood Lead Poisoning Prevention Program. How would these proposed budget cuts affect CDC's efforts to address the public health challenge of blood lead levels in children in Flint and nationwide? Please provide any documents that CDC has prepared that project the results of these proposed cuts on CDC's lead poisoning prevention efforts.

5. In its March 2016 response, CDC stated: "A nationwide CDC Lead Poisoning Prevention Program would enable jurisdictions to conduct robust surveillance of blood lead levels in children. If expanded, CDC would emphasize prevention and would target high-risk areas through blood lead surveillance efforts aimed at reducing or eliminating lead sources before children are exposed. We estimate that with additional resources CDC could expand [the Childhood Lead Poisoning Prevention

---

[10] Centers for Disease Control and Prevention, *Fiscal Year 2018: Justification for Estimates for Appropriation Committees* (www.cdc.gov/budget/documents/fy2018/fy-2018-cdc-congressional-justification.pdf) (accessed June 29, 2017); Pub. L. 115-31.

Program] to all 50 states, additional cities, and other localities with grant amounts that would allow for surveillance data to be used for more rigorous follow-up testing and case management, as well as collecting surveillance data at the local level." Is CDC planning to follow through on efforts to expand the Childhood Lead Poisoning Prevention Program to all 50 states? If not, why not?

6. In our February letter, we asked CDC if the agency would consider requiring states to make blood lead level testing results publicly available at the neighborhood level. In its response to our letter, CDC stated, "[w]hile CDC does not currently require funded states and cities to make their blood lead level surveillance data publicly available, we are considering including such a requirement in our FY 2017 [Funding Opportunity Announcement] FOA." Has CDC implemented this change? If not, is CDC still considering asking grantees to make their blood lead level surveillance data publicly available as a condition of receiving grant funding?

7. In our February letter, we raised concerns about the comprehensiveness and completeness of blood lead level testing data. In its March 2016 response, CDC stated that data collected under the Childhood Lead Poisoning Prevention Program varies greatly from state to state, and as a result, "these data cannot be accurately compared between or among states and counties." CDC further stated that "CDC's childhood blood lead surveillance data are not population-based estimates and are not representative of a whole county or state." What actions is CDC taking to ensure that states are providing accurate, timely, and complete blood lead level testing results to the agency? Is the agency undertaking efforts to ensure that the data are representative and complete, such that states can use the data to drive targeted public health interventions?

Thank you for your attention to this matter. If you have any questions, please contact Waverly Gordon or Kevin McAloon of the Democratic Committee staff at (202) 225-3641.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Gene Green
Ranking Member
Subcommittee on Health

Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations

Paul D. Tonko
Ranking Member
Subcommittee on Environment

Enclosure

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

March 14, 2016

The Honorable Frank Pallone, Jr.
Ranking Member, Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Representative Pallone:

Thank you for your letter inquiring about the Centers for Disease Control and Prevention's (CDC) Childhood Lead Poisoning Prevention Program and sharing your interest in better understanding the federal investment in lead poisoning prevention. CDC shares your concerns and is committed to working with our state, local, and federal partners to address elevated blood lead levels among children.

Enclosed please find responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this critical public health issue.

If you have any further questions or concerns, please contact Eric Wortman in the CDC Washington Office, at EWortman@cdc.gov or (202) 245-0600. This response is also being sent to the cosigners of your letter.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC

Enclosure

**Centers for Disease Control and Prevention (CDC) Response to the House Committee on Energy and Commerce regarding CDC's Childhood Lead Poisoning Prevention Program and Related Issues**

1. **Please provide all grant documents and reports submitted by MDHHS under CDC's Childhood Lead Poisoning Prevention Program.**
    a. **Please provide all grant documents and reports submitted by all other state agencies under the CDC's Childhood Lead Poisoning Prevention Program in the past five years.**

Separate from this response, CDC will provide the Committee with notices of grant awards and annual performance reports. Records for earlier years have been moved to a records storage facility, and additional time is needed to collect and transmit these documents. As my staff discussed with your staff, we will provide these documents for the following years:

- Notices of grant awards and annual performance reports for Michigan Department of Health and Human Services (MDHHS) from Fiscal Year (FY) 2006 through FY 2015; and
- Notices of grant awards and annual performance reports for all other health departments funded by this program from FY 2011 through FY 2015.

2. **According to news reports, Michigan state data confirmed a spike in blood lead levels after the city switched to the Flint River water source as early as July 2015; however, MDHHS officials originally claimed that this spike was "seasonal and not related to the water supply."**

**Was this a reasonable conclusion to draw?**

Multiple studies have confirmed that blood lead measurements vary seasonally.[1] Whether or not this was a reasonable conclusion would depend on the patterns and extent of the elevation.

    a. **Did MDHHS seek technical assistance from CDC in interpreting blood lead level results at any point in 2014-2015? If not should they have sought such assistance?**

CDC did not receive a specific request to interpret blood lead levels during this period. However, beginning in July 2015, CDC provided information and focused technical assistance to both MDHHS and the Genesee County Health Department at their request on:

- Case management processes and interventions for children with high blood lead levels;

---

[1] Interpreting and Managing Blood Lead Levels <10 μg/dL in Children and Reducing Childhood Exposures to Lead: Recommendations of CDC's Advisory Committee on Childhood Lead Poisoning Prevention, November 2, 2007 / 56(RR08);1-14;16. www.cdc.gov/mmwr/preview/mmwrhtml/rr5608a1.htm

[2] http://www.cdc.gov/nceh/lead/publications/leadandpregnancy2010.pdf

- Recommendations on educational interventions for children affected by lead;
- Appropriate blood lead reference levels for adults;
- Guidance on lead and pregnancy;[2]
- Water sampling protocol for inspections of homes with children with high blood lead levels and for responses to questions about whether affected water could be used to autoclave, sterilize instruments, and clean surfaces; and
- Inputs to using the Integrated Exposure Uptake Biokinetic model for assessing lead exposure in Flint.

In addition, CDC helped facilitate engaging U.S. Environmental Protection Agency (EPA) regional staff and others regarding possible assistance that could be provided.

3. **According to a release by HHS, CDC has presented recommendations for lead testing in children to MDHHS that all children 6 years and under be tested by April 1, 2016 and that subsequent services are identified for children who have a blood lead level of 5 micrograms/deciliter or more.**
    a. **Please provide additional detail on these recommendations, and what subsequent services should be recommended for children who have a blood lead level of 5 micrograms/deciliter or greater.**

CDC, in collaboration with other U.S. Department of Health and Human Services (HHS) agencies, is providing site specific recommendations to MDHHS and Genesee County Health Department on follow-up for blood lead testing and subsequent services for children who have blood lead levels of 5 µg/dL or higher. For children in Flint with blood lead levels of 5 µg/dL or higher, CDC recommends a confirmatory blood lead test and subsequent assessment and management of environmental, nutritional, developmental, and behavioral risk factors associated with high blood lead levels. CDC site specific recommendations to MDHHS and Genesee County Health Department also call for a case management home visit within the time frames outlined in the table below. These site specific recommendations were developed based on an assessment of community needs as a result of the public health crisis of lead in the water system and 2012 recommendations from CDC's Advisory Committee on Childhood Lead Poisoning Prevention, a chartered federal advisory committee.

| Blood Lead Level | Recommended Timing of Case Management Home Visit |
|---|---|
| 5–14 µg/dL | within two weeks of referral |
| 15–44 µg/dL | within one week of referral |
| 45+ µg/dL | within 48 hours of referral |

State and local health officials are coordinating with health care providers and others to implement this guidance.

    b. **Given the prevalence of blood lead levels of 5 micrograms/deciliter or more in many cities beyond Flint, will CDC be issuing similar recommendations to other states, cities, or municipalities that have documented elevated blood lead levels in children?**

The city-wide site specific recommendations made for Flint were based on an assessment of community needs as a result of the public health crisis of lead in the water system. At this time, CDC is not considering issuing similar city-wide site specific recommendations to other states, cities, or municipalities. City-wide site specific recommendations were necessary in Flint, because the entire population on the city's water system was known to have been exposed to lead levels significantly above those permitted by the Safe Drinking Water Act.

CDC continues to provide support to other grantee state and local health departments to identify and address lead exposure in areas that the grantees identify as highest risk in their jurisdictions. The Childhood Lead Poisoning Prevention Program maximizes impact by targeting resources to the areas at highest risk for lead exposure. Grantees work hard to test children most likely to have high blood lead levels.

In 2012, CDC defined a reference level of 5 µg/dL to identify children with elevated blood lead levels. These children are exposed to more lead than most children. This reference range value is based on the 97.5th percentile of the 2007–2010 National Health and Nutrition Examination Survey's (NHANES) blood lead distribution in children. CDC updates the reference range value every four years using the two most recent NHANES surveys.

4. **Tragedies like Flint Michigan, underscore the importance of CDC's role in providing funding and technical assistance for surveillance of blood lead levels through the Childhood Lead Poisoning Prevention Program. Surveillance to detect high risk areas and "hot spots" is the key to designing appropriate and timely public health interventions to address this public health challenge. Yet funding for the program has declined significantly since FY 2011, and according to news reports, twenty-one states do not submit any kind of lead surveillance data to the CDC.**
    a. **Please provide a briefing for Democratic Committee staff on the history of the Childhood Lead Poisoning Prevention Program, historic funding levels, and programmatic activities conducted by recipients under the grant.**

CDC would be pleased to provide a briefing on the history, activities, and funding level of the Childhood Lead Poisoning Prevention Program. Our CDC Washington Office will work with Committee staff to make arrangements.

    b. **Given the emerging consensus that no level of lead in the blood is safe in children, should the program be expanded to ensure that all major cities and all states have robust surveillance capabilities? If so, what additional resources does the agency need to expand the program?**

A nationwide CDC Lead Poisoning Prevention Program would enable jurisdictions to conduct robust surveillance of blood lead levels in children. If expanded, CDC would emphasize prevention and would target high-risk areas through blood lead surveillance efforts aimed at reducing or eliminating lead sources before children are exposed. We estimate that with additional resources CDC could expand to all 50 states, additional cities, and other localities with

grant amounts that would allow for surveillance data to be used for more rigorous follow-up testing and case management, as well as collecting surveillance data at the local level.

One of the goals of HHS's Healthy People 2020[2] agenda is to eliminate childhood lead poisoning as a public health problem. CDC, the Department of Housing and Urban Development, the U.S. EPA, and other agencies have developed a federal interagency strategy to achieve this goal by 2020. The key elements of this interagency strategy include

1. Identification and control of lead paint hazards;
2. Identification and care for children with elevated blood lead levels;
3. Surveillance of elevated blood lead levels in children to monitor progress; and
4. Research to further improve childhood lead poisoning prevention methods.

**c. Are there any additional resources or authorities that the agency needs to address the public health challenge of lead poisoning in children?**

CDC is authorized under the Public Health Service Act, as amended, to initiate programs to eliminate childhood lead poisoning in the United States. CDC will advise the Committee if we identify additional authorities needed to address lead poisoning in children. Additional resources for the lead program are addressed in response to question 4b above.

In addition, CDC's Safe Water program does not support all relevant activities in all states. Currently, CDC's safe water program directly funds 19 state and local health departments to identify and address drinking water program performance gaps and identify and reduce exposures that can lead to contamination of drinking water.

**5. According to one reporter who contacted the 6 cities currently receiving CDC Childhood Lead Poisoning Prevention Program funding—Houston, Philadelphia, Los Angeles, Washington, DC, Chicago, NYC—only 2 were able to provide lead exposure data at the neighborhood level. The other 4 recipients did not make blood lead level results easily accessible to the public.**

**a. Is this an accurate characterization? Are grant recipients not required to make results of blood lead levels available to the public?**

We are unable to assess if this an accurate characterization without knowing which communities responded to the reporter's inquiry. CDC's FY 2014 Funding Opportunity Announcement (FOA)[3] for the Childhood Lead Poisoning Prevention Program required funded programs to share data with groups across states and cities "to assist in the development and implementation of appropriate interventions" and to integrate into or interface with other environmental public

[2] http://www.cdc.gov/nchs/healthy_people/hp2020.htm
[3] CDC-RFA-EH14-1408PPHF14

health databases[4] and state and federal programs and authorities.[5] The FOA also requires states to collect the address of children tested for lead exposure and to maintain this information in their Healthy Homes Lead Poisoning Surveillance System. The FOA does not require the release of neighborhood blood lead level data or require public availability of blood lead level data.

When states submit quarterly blood lead level data to CDC, the city and zip code are provided to CDC as part of a set of core data variables established by CDC and participating states. These variables are described in more detail in the response to question 6a. CDC's requirements for sharing blood lead level surveillance data are designed to encourage and facilitate interventions to address elevated blood lead levels in the places of greatest need, and grantees are encouraged to use and share data with other state, federal, and community organizations.

**b. Would CDC consider making this a grant requirement or recommendation in the future? Could greater transparency in lead surveillance programs provide actionable and relevant information to families in high risk areas about potential lead exposure issues?**

While CDC does not currently require funded states and cities to make their blood lead level surveillance data publicly available, we are considering including such a requirement in our FY. 2017 FOA.

**c. Additionally, according to the article, some grant recipients are only reporting lead exposure incidents where the level of lead in the blood is 10 micrograms/deciliter instead of the 5 micrograms/deciliter reference level established by CDC in 2012. Should health departments be reporting lead exposure incidents using the 5 micrograms/deciliter reference level? What can CDC do to encourage or require such reporting?**

States funded by the Childhood Lead Poisoning Prevention Program report all collected blood lead results to CDC, not just elevated results. While CDC has made recommendations to state and local health departments on reporting blood lead levels within their jurisdictions and on the reference level for intervention, individual states adopt their own practices as determined by their own state laws. For example, CDC recommends laboratories report all blood lead levels, not just elevated levels, to state or local health departments, and though most states have adopted this practice, some states have other legal requirements, such as mandatory reporting of only elevated blood lead levels. Also, not all states have adopted CDC's most recent reference level for intervention of $\geq$5µg/dL, established in January 2012.

In 2012, CDC defined a reference level of 5 µg/dL to identify children with elevated blood lead levels. These children are exposed to more lead than most children. This reference range value is

---

[4] E.g., immunization registries; Adult Blood Lead Epidemiology and Surveillance [ABLES]; Environmental Public Health Tracking Network; Medicaid; Health Resources and Services Administration [HRSA] Title V; Early Childhood Home Visiting Programs; and Special Supplemental Nutrition Program for Women, Infants and Children [WIC].

[5] Programs are required to integrate or interface with state and local housing, education, and environmental quality authorities; and housing data including that for housing code enforcement agencies and publicly owned or subsidized property and Housing and Urban Development (HUD) collaborative programs.

based on the 97.5th percentile of the 2007-2010 NHANES blood lead distribution in children. CDC updates the reference range value every four years using the two most recent NHANES surveys. Until recently, children were identified as having a blood lead "level of concern" if the test result was 10 or more μg/dL of lead in blood. CDC is no longer using the term "level of concern" and is instead using the reference range value to identify children with elevated blood lead levels. CDC recommends but does not require interventions for children with blood lead levels of ≥5 μg/dL.

CDC continues to make recommendations to state and local health departments to give jurisdictions with elevated blood lead levels the help they need.

6. **According to news reports, even those states that submit data regularly to CDC on blood lead levels do not appear to submit comprehensive or complete data. Some states appear to be providing results based on very small sample sizes, making it difficult to draw any conclusion about whether they are representative. In Texas for instance, only 184 children were tested for lead poisoning in 2014, although the state's population of kids under six exceeds 2 million. States such as Alabama appear to only test kids that they suspect have been exposed to lead, as opposed to more broad-based testing.**

    a. **Does CDC require or recommend that states use any particular sampling or testing methodologies to ensure that results are representative? Does CDC provide any guidance on who should be tested or what data should be reported to CDC? Should health departments be using larger sample sizes in order to provide the public with a more accurate picture of lead hazards in their communities? What can CDC do to encourage or require states to use larger or more representative sample sizes?**

CDC and other organizations, such as the American Academy of Pediatrics[6], provide guidance on who should be tested by local health departments and health care providers: children under age 6 who are at higher risk for lead exposure, including children who are poor; members of racial or ethnic minority groups; and recent immigrants living in older, poorly maintained rental properties, or have parents who are exposed to lead at work.

The Childhood Lead Poisoning Prevention Program requires grantees to use surveillance data to identify the highest risk areas and implement appropriate population-based interventions wherever needs are identified. Targeting resources to children determined to be at highest risk maximizes the impact of limited resources. As a result, CDC's childhood blood lead surveillance data are not population-based estimates and are not representative of a whole county or state.

State-level blood lead surveillance is based on reports of blood lead tests from laboratories to state health departments. Ideally, laboratories report results of all blood lead tests, not just elevated results. States determine the reporting level for blood lead tests and decide which data should accompany the blood lead test result. CDC's Healthy Homes Lead Poisoning Surveillance System is available to states, both funded by our Childhood Lead Poisoning Prevention Program and unfunded, to track blood lead results and risk factors at the state level.

States vary in the number of children they test and identify with high blood levels due to a variety of factors. Because of this, these data cannot be accurately compared between or among states and counties. Comparisons can be affected by county size, number of children tested within the counties, and number of children in the counties who are reported to have high blood lead levels. For example, some counties may have a small number of children tested, but many of those tested have high blood lead levels. Not all children are tested, so some statistics could underestimate the number of children with lead exposure.

CDC requires states funded under the Childhood Lead Poisoning Prevention Program to report all blood lead data to CDC. We house the state-reported data in our Childhood Blood Lead Surveillance System. CDC and participating states established a set of core data variables that should be collected for every child at the time of the blood lead test when it is taken at the local health department or health care provider's office. These variables include identification and demographic information (e.g., date of birth, race, ethnicity), laboratory information (e.g., venous or capillary blood test), date of blood lead test, address information (e.g., city and zip code), and test result. Records are de-identified and de-duplicated; and the child associated with each record is assigned a unique identifier that is sent to CDC along with the data.[7]

Currently, Texas and Alabama state health departments are not funded by CDC's Childhood Lead Poisoning Prevention Program. However, the City of Houston is a grantee and is one of five cities plus the District of Columbia that is funded under the program. Alabama and Pennsylvania are two unfunded states that voluntarily provided lead data to CDC in 2015.