

ONE HUNDRED FOURTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**  
COMMITTEE ON ENERGY AND COMMERCE  
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May 17, 2016

Mr. Nick Lyon  
Director  
Michigan Department of Health and Human Services  
201 Townsend Street  
Lansing, MI 48913

Dear Mr. Lyon:

Thank you for appearing before the Subcommittee on Health and the Subcommittee on Environment and the Economy on April 13, 2016, to testify at the hearing entitled "Flint Water Crisis: Impacts and Lessons Learned."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 27, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to [graham.pittman@mail.house.gov](mailto:graham.pittman@mail.house.gov).

Thank you again for your time and effort preparing and delivering testimony before the Subcommittees.



John Shimkus  
Chairman  
Subcommittee on Environment  
and the Economy

Sincerely,



Joseph R. Pitts  
Chairman  
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health  
The Honorable Paul Tonko, Ranking Member, Subcommittee on Environment and the Economy

Attachment

## Attachment — Additional Questions for the Record

### The Honorable Michael C. Burgess

1. The Flint Water Advisory Task Force, among a long list of other recommendations, suggested that a Toxic Exposure Registry be implemented by the State to monitor the ramifications of the wide-spread lead poisoning in the city. Understandably, this task could be resource-heavy to execute. What resources does the State of Michigan have available to monitor disease and outbreaks? Could these resources be used to monitor the emergency in Flint in lieu of federal assistance?
2. The state has promised long-term care and other services for the children of Flint who have tested positive for “elevated blood lead levels”. In determining that status for children, is the state using a specific threshold for “elevated blood lead levels” or simply any discernable trace of lead in the child’s blood? How will the state determine which children are ultimately eligible to receive services? How will the state care for children that were exposed to lead but were not screened within the appropriate window to test positive for lead exposure?

### The Honorable Frank Pallone, Jr.

During the hearing, you were asked about a July 2015 MDHHS memo that observed a spike in blood lead levels in the summer of 2014, after the city switched to the Flint River water source. MDHHS officials originally concluded that this spike was seasonal and not related to the water supply. We sent you a letter on February 22, 2016, asking for more information on the MDHHS memo. Please answer the following questions relating to our February 22 letter and your testimony at the hearing:

1. Has the Department changed its surveillance practices since July 2015?
2. In hindsight, what lessons have you learned as a result of these events? How can we strengthen surveillance to ensure that spikes in blood lead levels in children are detected in a timely manner and that determinations of correlation and causation are made when appropriate?

Also in the February 22 letter, you were about Dr. Hanna-Attisha’s findings that the blood lead levels of children in Flint had increased significantly following the switch to the Flint River water source. State officials suggested that Dr. Hanna-Attisha’s data differed from their own data, which showed “no increase outside the normal seasonal increases.”

3. In hindsight, what lessons have you learned as a result of these events? How do you and officials in your department believe we can strengthen surveillance of blood lead levels in children?

In your response to the February 22, 2016 letter, you did not provide answers to several of the questions. Please submit answers to the following questions:

The July 2015 MDHHS memo confirmed a spike in blood lead levels in the summer of 2014, after the city switched to the Flint River water source; however, MDHHS officials originally claimed that this spike was “seasonal and not related to the water supply.”

4. What led MDHHS to compile the July 2015 report?
5. What was the basis for MDHHS’s conclusion that the spike was not related to the water supply?
6. Did MDHHS seek technical assistance from the CDC or any other experts in interpreting blood lead level results? If not, should the agency have considered seeking such assistance?
7. Please provide all documents and communications related to this report.
8. The July 2015 report indicated that “[d]ata for the City of Flint was provided by the Childhood Lead Poisoning Prevention Program at the Michigan Department of Health and Human Services.” How is that data compiled? How frequently is it compiled? What data was provided to assist in compiling the July 2015 report?

In September 2015, State officials received Dr. Hanna-Attisha’s findings that Flint children’s blood lead levels had increased significantly following the switch to the Flint River. State officials suggest it is different from their own data, which showed “no increase outside the normal seasonal increases.”

9. How was MDHHS conducting blood lead level testing? How was that different from Dr. Hanna-Attisha’s methodology?
10. What steps, if any, did MDHHS take to verify Dr. Hanna-Attisha’s findings?
11. Please provide all documents and communications related to Dr. Hanna-Attisha’s findings, including documents related to any efforts to verify or refute her findings.

The Flint Water Advisory Task Force recommends that the Governor issue an Executive Order mandating guidance and training on environmental justice across all state agencies in Michigan, pointing to Flint as an example. Additionally, the task force recommends that the State reinvigorate and update implementation of an Environmental Justice Plan for the State of Michigan.

12. Do you agree with these recommendations? Is your department engaged in efforts to implement them?
13. The task force recommends that MDHHS consider “converting the Childhood Lead Poisoning Prevention Program from passive collection of test results into an active surveillance and outreach program.” Is MDHHS planning to implement this recommendation? Is MDHHS considering any other improvements to the Childhood Lead Poisoning Prevention Program so it is better equipped to track trends in lead exposure?

The task force recommends that MDHHS “improve screening rates for lead among young children through partnerships with county health departments, health insurers, hospitals, and healthcare professionals.”

14. Do you agree with this recommendation? Why or why not?
15. What is the status of Flint’s comprehensive effort to ensure all children under age 6 are screened for lead? What does MDHHS plan to do with the data derived from this screening effort?
16. What actions does MDHHS plan to take to improve screening rates across the State of Michigan?

In April 2016, there were press reports confirming two more fatal cases of Legionnaires’ disease in the Flint area last year. Of the 91 cases in 2015 now confirmed by the Michigan Department of Health and Human Services, 50 were linked to a Flint hospital served by the municipal water system.

17. Can you confirm these figures for Legionnaire’s disease in the State in 2015?

The Flint Water Advisory Task Force analyzed the state’s response to the Legionnaire’s disease outbreak. The task force found that “communication and coordination among local and state public health staff and leadership regarding Legionellosis cases in 2014-2015 was inadequate to address the grave nature of this outbreak.”

18. Have you undertaken efforts to improve coordination at the state and local levels regarding this outbreak?
19. The task force recommended that MDHHS make a formal request to CDC for assistance in assessing this disease outbreak. Has that occurred?
20. The task force recommended that MDHHS develop a strategy for improving prevention, rapid detection, and timely treatment of cases of Legionnaire’s disease in Michigan in 2016 and beyond. Has that occurred?
21. Is MDHHS undertaking any evaluation to understand whether this disease outbreak is linked to the 2014 shift to drinking water from the Flint River? Please update us on the status of this evaluation.

The Flint Water Advisory Task Force concluded that “[t]he rate of follow-up on children with elevated blood lead levels through January 2016 was unacceptable, illustrating a low level of coordination between the Genesee County Health Department, which serves Flint, and the Michigan Department of Health and Human Services and insufficient resources devoted to this task.” According to that report, as of late January 2016, only about one-fifth of children known to have elevated blood lead levels in Flint since April 2014 had received in-home environmental assessments, which include water testing.

Please provide the Committee with an update on both the number of children who have been identified as having elevated blood lead levels and what percentage of those children have received the recommended environmental follow-up.

22. When do you expect that all affected children will have received this follow-up?
23. Are there barriers or resource constraints that have prevented Michigan from ensuring that all the identified children receive the recommended environmental follow-up?
24. What strategies are the Michigan Department of Health and Human Services or Genesee County Health Department using to increase the number of identified children who have received the recommended environmental follow-up?

### **The Honorable Gene Green**

In February of this year, I, along with Ranking Member Pallone, Rep. DeGette, and Rep. Tonko, sent a letter to the Michigan Department of Health and Human Services (MDHHS) to better understand the role of blood lead level surveillance in the Flint crisis.

The Department answered some, but not all of our questions, in its response dated March 11, 2016. I want to follow-up on some of those questions today to better understand how we can improve surveillance of blood lead levels in children, both in Michigan and across the country.

In our February 22 letter, we asked you about a July 2015 MDHHS memo that observed a spike in blood lead levels in the summer of 2014, after the City of Flint switched to the Flint River as its drinking water source. However, MDHHS officials originally concluded that this spike was seasonal and not related to the water supply.

1. Mr. Lyon, what led your Department to compile the July 2015 report?
2. Why did MDHHS conclude that the spike was not related to the water supply?
3. In hindsight, what lessons have you learned as a result of these events? How can we strengthen surveillance to ensure that spikes in blood lead levels in children are detected in a timely manner?
4. In our letter, we requested all documents and communications related to this report. We believe that these documents are important to enhance our understanding of how to strengthen surveillance and what lessons we should draw from Flint. Would you be willing to provide us with these documents?

Thank you. Similarly, in our February 22 letter, we asked about Dr. Hanna-Attisha's findings that Flint children's blood lead levels had increased significantly following the switch to the Flint River water source. State officials suggested that Dr. Hanna-Attisha's data differed from their own

5. Mr. Lyon, can you explain the discrepancy between the state's own data and Dr. Hanna-Attisha's findings?
6. In hindsight, what lessons have you learned as a result of these events?
7. In our letter, we requested all documents and communications related to Dr. Hanna-Attisha's findings. Would you be willing to provide us with these documents moving forward?
8. Do you have anything else to add about how we can strengthen surveillance of blood lead levels in children?

Thank you. We appreciate your responsiveness and cooperation with our inquiry.

### **The Honorable Lois Capps**

The CDC's Childhood Lead Poisoning Prevention Program provides funding to state health departments to screen children for elevated blood levels. Through this program, Michigan's Department of Health and Human Services received \$327,353 in FY 2014. In 2012-2013, Congress nearly zeroed out funding for this federal program and only partially restored it recently, to 50% of original levels. The impact of lead poisoning in children is of particular concern, especially due to the tremendous long-term effects on growth and development.

1. Can you talk about what you are you doing to strengthen Michigan's blood lead level monitoring program?
2. What are some lessons learned, and considerations we should take into account as we consider how to strengthen the program on a national level?

### **The Honorable Michael Doyle**

1. Why isn't the state government providing long-term, coordinated medical care and monitoring of the medical conditions of Flint residents? And, given the level of distrust now, what is the administration in your state doing to restore that trust? Wouldn't consulting with credible outside entities both ensure Flint residents have access to essential care and help to restore their trust?
2. Why isn't the state government providing central, coordinated care and monitoring for all Flint residents? Not just those who qualify under the Medicaid wavier exception—every single resident? How will you pay for it? Who will run it? When will it be in place?
3. Why isn't the state providing ongoing care for lead exposure related conditions for both children and adults instead of relying on blood tests and donated medical services? Why aren't you monitoring other issues besides blood lead levels? Are there sufficient medical resources within the City of Flint to provide the type of care needed? How do you know? When are you going to start focusing on long-term solutions, rather than putting Band-Aids on this problem? How will you pay for them? Who will you work within Flint to make sure these solutions are working?