June 6, 2018

Chairman Michael Burgess
Energy & Commerce Health Subcommittee
2125 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Ranking Member Gene Green
Energy & Commerce Health Subcommittee
2322A Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Congresswoman Susan Brooks
1030 Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Congresswoman Anna Eshoo
241 Cannon House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Burgess, Ranking Member Green, and Representatives Brooks and Eshoo:

On behalf of Trust for America's Health (TFAH), I am pleased to offer comments for the record on the discussion draft of the Pandemic & All-Hazards Preparedness Reauthorization Act of 2018 (PAHPRA) for today's legislative hearing. TFAH is a non-profit, non-partisan organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. We do not accept any government funding or represent any groups that benefit from the programs authorized in this legislation. As such, we strive to be an independent voice on behalf of strengthening America's public health and preparedness systems. While we look forward to working with your staff with more detailed recommendations, we offer the following comments on several provisions within the legislation:

Public Health Emergency Medical Countermeasures Enterprise (Sec. 102): We support codification of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE). However, the PHEMCE should encompass the medical countermeasures (MCM) process from research and development through distribution and dispensing. Having appropriate medicines and vaccines are useless without the capacity to dispense those products to the right patient at the right time. If products are developed without an understanding of the supply chain management capabilities, the populations being targeted, and the capabilities of the health departments and others that will oversee distribution, there will be a tremendous loss in terms of resources and lives. We urge the authors to add "distribution and dispensing" to the functions of PHEMCE in sec. 102 to ensure the product can reach the patient.

Public Health Emergency Response Fund (Sec. 201): While we support the concept of an emergency response fund ("Fund"), we have several concerns with this section as currently written. First, we object to resourcing the Fund through transfer from other programs. We

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learned during the Zika outbreak that reducing programs by up to 1 percent can have immediate consequences and harms the nation's health security. In a survey of local health departments following the redirection of all-hazards preparedness funds to support the Zika response, respondents reported negative impacts on pre-event readiness, supplies, staffing and other areas.[1] These are capabilities not easily backfilled with short-term funds.

Second, we are concerned with language in this section that seems to make funds available for the Secretary to develop and procure MCMs under any circumstances, not just in emergency situations (p. 8 lines 21-24). At a minimum, this paragraph should be re-lettered to clarify that MCM development is an appropriate use of the Fund if the other circumstances described in the establishment clause are met. We strongly urge the authors to either delete this paragraph or to include a more complete list of appropriate uses of the Fund, including public health, biosurveillance and medical response activities. Third, because the Fund should be a bridge between preparedness and other response funds, we ask that language be added to the "Supplement not supplant" section that clarifies that funds should also not supplant other emergency appropriations allocated to respond to the identified crisis. Finally, we urge the Committee to require the Secretary to plan for expedited distribution of funds to appropriate entities and agencies under this section.

Improving State and Local Public Health Security (Sec. 202): We are strong supporters of the Public Health Emergency Preparedness (PHEP) cooperative agreement, which is the main source of funding to enable health departments to prevent, contain and respond to emergency health threats. We are concerned that the authorization levels in this section are too low to rebuild the program from a nearly 30 percent cut over the past 15 years. PHEP should be authorized at least at $824 million, the levels authorized in the PAHPA legislation of 2006. In addition, we urge the Committee to add language clarifying that the PHEP cooperative agreement should continue to be administered through the Centers for Disease Control and Prevention (CDC). Since the inception of the PHEP program, CDC has served effectively as the lead agency for developing public health capacity with state, territorial and local health departments. CDC's expertise and relationship with health departments has created a valuable partnership that has contributed to the nation's overall health security.

Partnerships for State and Regional Hospital Preparedness to Improve Surge Capacity (sec. 203): We are concerned that the authorized levels for the Hospital Preparedness Program (HPP) in this section are very low. HPP's highest level of appropriation was $515 million, yet the program has eroded to only $267 million, a vastly insufficient level given the task of preparing the health care system for a surge of patients, continuity of operations, and recovery. HPP should be authorized at least at $474 million, the level authorized in the PAHPA

[1] *Impact of the Redirection of Public Health Emergency Preparedness (PHEP) Funding from State and Local Health Departments to Support National Zika Response*. ASTHO, NACCHO, APHL and CSTE, 2016. https://www.naccho.org/uploads/downloadable-resources/Impact-of-the-Redirection-of-PHEP-Funding-to-Support-Zika-Response.pdf

legislation of 2006. As the Centers for Medicare & Medicaid Services (CMS) emergency preparedness rule goes into effect, the U.S. Department of Health and Human Services (HHS) expects as many as 50,000 health care facilities to seek inclusion in health care coalitions. The legislation appropriately adds "response" to the mission of HPP, which would not be possible to achieve without additional funding. This level would allow rebuilding of the program as it transitions from capacity building to operationalizing health care coalitions for response.

Strategic National Stockpile (Sec. 301): We support the funding levels in this section. However, we are concerned with the paucity of detail on how a transfer of the Strategic National Stockpile (SNS) from CDC to the Assistant Secretary for Preparedness and Response (ASPR) would improve the program and health security. It is important to remember that the SNS is not simply a procurement or stockpiling program; it is also a public health program and system of distribution and dispensing. CDC offers several SNS capabilities that would need to be considered, even beyond the Divisions of SNS (DSNS). For example, DSNS works with the Division of State and Local Readiness (DSLR) to help PHEP awardees prepare to receive, distribute and dispense materiel from the stockpile. In fact, MCM distribution and dispensing is a key capability of the PHEP grants. The committee should ensure the transfer does not harm the existing cooperation and resources between DSNS and DSLR to develop health department MCM capabilities and address gaps. In addition, the DSNS currently has access to expertise across CDC. In the midst of the Zika outbreak, for example, experts in vector-borne diseases, birth defects and maternal health, sexually transmitted infections, emergency preparedness and response, blood safety and others all populated the CDC Emergency Operations Center. If you move ahead with this transfer, we urge the Committee to include provisions requiring ASPR to develop strategies to ensure that SNS can continue to access this expertise and by explicitly giving CDC an ongoing role in the SNS enterprise.

Cybersecurity (sec. 401): While we understand the problem that cyber threats pose to the security of our nation's health care and public health systems, we question adding cybersecurity to the responsibility of the Assistant Secretary for Preparedness and Response, the PHEP awards, and the PHEMCE without additional funding. Cybersecurity is an enormous and technical task, and the ASPR and public health staff have little existing expertise or capacity to address the threat without significant new resources. We urge the Committee to take a step back and hold additional hearings to consider options for the role of HHS in cybersecurity before legislating.

Workforce: We are concerned that the legislation does not address gaps in the public health, environmental health and epidemic response workforce. For example, we recommend the legislation include a provision to provide loan repayment to help the CDC recruit individuals to serve as Epidemic Intelligence Service (EIS) officers. We also urge the Committee enable CDC to hire informatics professionals to address modern biosurveillance needs of the agency.

Thank you for the opportunity to offer our comments for today's hearing. We look forward to continuing to work with the Committee on this important legislation.

Sincerely,

John Auerbach, MBA
President & CEO