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@ASTHO

May 21, 2018

The Honorable Lamar Alexander
Chairman
Health, Education, Labor and Pensions Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member
Health, Education, Labor and Pensions Committee
U.S. Senate
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the Association of State and Territorial Health Officials (ASTHO), we are pleased to submit this letter regarding the “The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2018” (S. 2852). ASTHO is the national nonprofit organization representing the state and territorial public health agencies of the United States, U.S. territories, and Washington, D.C. ASTHO’s members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and assuring excellence in public health practice.

We are pleased that much of the bill retains elements proven to be necessary, reasonable, and successful, and while making further refinements to the underlying statute, as well as responding to and including many of our suggested edits, clarifications, and acknowledgments of the importance of state, local, territorial, and tribal public health and its essential contribution to this endeavor. ASTHO strongly supports the reauthorization of the Public Health Emergency Preparedness Program (PHEP) and the Hospital Preparedness Program (HPP). PHEP and HPP are key to the foundational capabilities of public health preparedness and healthcare, respectively. We also support codifying the role of CDC to administer the PHEP program.

As the Health, Education, Labor, and Pensions Committee marks up the bill this week, we respectfully request the following refinements.

Sec. 202: Amendments to Preparedness and Response Programs

- The \$685 million authorization level for the Public Health Emergency Preparedness Program (PHEP) and \$385 million for the Hospital Preparedness Program (HPP) in the bill are significantly lower than our suggested levels of **\$824 million for PHEP** and **\$474 million for HPP**. We strongly urge you to increase the authorization levels. As one of our members shared with you during testimony at a HELP Committee hearing, which he was honored to provide, “the people are the net.” We fear funding at this proposed level is unlikely to support the vital positions, relationships, training, and local, collaborative, trusting, emergency response capacity required—put simply: the public health emergency response safety net. It simply cannot be produced by follow-on funding, even with immediate injection after the fact. Funding at these levels will cost us more in the long run, both in dollars and in lives.
- We are also concerned about Sec. 202(d)(1)(B), specifically the “reservations of amounts for regional systems.” The HPP program is already funded at a vastly insufficient level given the task

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of preparing the healthcare system for a surge of patients, continuity of operations, and recovery. Any fund reductions to HPP through a tap will have an adverse impact on real-time all-hazards preparedness and response activities carried out by the existing healthcare coalitions. The costs associated with exploring the development of a regional system or network should not be at the expense of current critical medical readiness and patient care services.

Sec. 203: Regional Health Care Emergency Preparedness and Response Systems

ASTHO supports the bill's language calling for the development of guidelines and the option for a demonstration project for regional public health emergency preparedness and response systems and ensuring the inclusion of the public health sector in the planning period.

Sec. 205: Strengthening and Supporting the Public Health Emergency Rapid Response Fund

- ASTHO appreciates that the bridge fund was renamed to the "rapid response fund." We feel this is more indicative of its intent. The clarifying language beyond the title is also useful and we appreciate that the bill strengthens existing authorities for the Public Health Emergency Fund (PHEF). We continue to urge Congress to create a mechanism to fund and replenish the PHEF. Without sufficient, dedicated funding, it will be impossible to quickly access funds when needed. Further, it is important that the PHEF does not transfer money away from existing public health and preparedness resources, but supplement these important programs.
- We are grateful to see the acknowledgement that the HHS Secretary should move to establish mechanisms to distribute funds in a rapid manner, such as the CDC "Crisis NOFO."
- We also appreciate and support the clarification that funds can be used for grantmaking, awards, contracts, and conducting supportive investigations to a public health emergency or potential public health emergency.

While not addressed in either the discussion draft nor the introduced version, ASTHO continues to urge the HELP Committee to consider improving efficiency and strategic planning for the use of PHEP and HPP funds to reduce administrative burdens on state public health departments and offers the following suggestions:

1. Multi-year funding awards with 24-month budget periods and the ability to redirect funds during the budget period, would provide spending authority so that projects can be funded, carried out, and paid for over the full 24 months. This would considerably reduce the administrative burden of processing carryover and no-cost extension requests.
2. Elimination of the Maintenance of Effort (MOE) while continuing the 10 percent match requirement would also reduce administrative burden while still maintaining investment from both the public and private sectors in preparedness.
3. Notwithstanding any existing provisions to the contrary, formally allow state, local, and territorial public health staff funded through federal categorical cooperative agreements and grants to allocate up to 5 percent of their time to participate in pre-incident preparedness-oriented training and exercises, as well as be assigned to response activities. This will help promote an agency-wide culture of preparedness and would enable state, local, and territorial public health departments to more easily and quickly redirect, on a temporary and limited basis,

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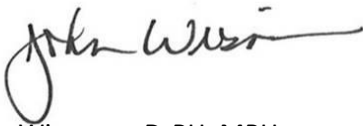
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existing, skilled staff to serve as a force multiplier without the impediment of funding source restrictions (e.g., general funds vs. federal categorical grant funding) when needed and would serve an important purpose, especially during those smaller-scale events when additional personnel are needed, but the threshold for formal temporary redirection of personnel is not met.

We applaud your commitment to the reauthorization of the Pandemic and All-Hazards Preparedness Act. Please contact Carolyn McCoy (cmccoy@astho.org), ASTHO's senior director of government affairs, for additional information.

Sincerely,



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ASTHO President, Secretary of Health,
Washington State Department of Health
Olympia, WA



John J. Dreyzehner, MD, MPH, FACOEM
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