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June 19, 2018

Chairman Michael Burgess
Energy & Commerce Health Subcommittee
Washington, D.C. 20515

Ranking Member Gene Green
Energy & Commerce Health Subcommittee
Washington, D.C. 20515

Dear Chairman Burgess, Ranking Member Green:

On behalf of the Association of State and Territorial Health Officials (ASTHO), we are pleased to submit comments on the discussion draft legislation entitled the "Pandemic and All-Hazards Preparedness Reauthorization Act of 2018." 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 state-based public health practice.

State and territorial public health departments have a critical role in national security and have increased their individual and collective capacity, capabilities, and impact over the last 15 years to manage the consequences of local, state, regional, and national emergencies more effectively, saving lives and preventing or reducing injury and illness. These accomplishments are due, in large part, to the leadership, strategy, policy, and the investments provided by the federal government in state and local partners, to build and sustain a strong public health and medical preparedness system. Our accomplishments and successes can be directly attributed to the Pandemic and All Hazards Preparedness Act. This Act, both in its initial and first reauthorization form, was transformational as it pertains to public health and healthcare preparedness and has provided the requisite direction, authorities, and authorization of resources to enable our members to do their job in the best way possible. ASTHO is pleased that the draft legislation acknowledges 21st century issues such as threats to our cyber security. This reflects the ability of this legislation to evolve with threats as they arise.

While the draft legislation includes important provisions such as reauthorizing the Public Health Emergency Preparedness Program (PHEP) and Hospital Preparedness Programs (HPP) programs, ASTHO has concerns with other components of the bill. We believe the legislation should be improved in the areas including authorization levels, funding for the emergency fund, provisions related to HPP and the Strategic National Stockpile, codifying the role of CDC in administering the PHEP program and addressing administrative efficiencies such as deleting the maintenance of effort requirement. Below please find our detailed overview of the bill indicating some provisions we support, areas for enhancement, and current gaps in the existing draft. Please note our comments on the discussion draft legislation are primarily focused on the provisions that will impact state and territorial public health departments.

Sec. 102 Public Health Emergency Medical Countermeasures Enterprise

ASTHO encourages the Energy and Commerce Committee to include a state and local public health department representative as a member of the public health emergency medical countermeasures enterprise. Therefore, in (b) Members- state and local public health should have a permanent place in the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) membership to ensure

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that all decisions that will affect state and local health functions are vetted by public health authorities. Membership should include a state public health authority and a local public health authority.

The functions of PHEMCE should be strengthened by requiring ASPR to routinely solicit and incorporate state and local feedback regarding medical countermeasures to ensure that critical decisions affecting dispensing operations taken into local planning and tactical concerns. Without coordination, state and local entities will inevitably face additional hurdles to achieving their missions.

Sec. 201 Public Health Emergencies

ASTHO is extremely concerned about the new provision regarding uses of the fund does not include natural disasters under subsection (c). We therefore strongly urge the committee to include in bold on page 8 subsection c “To prevent, prepare for or respond to,”

- (i) a chemical, biological, radiological or nuclear threat
- (ii) an emerging infectious disease
- (iii) **natural disaster**

While ASTHO does not necessarily oppose the inclusion in the purposes for the fund the provision “to develop and procure medical countermeasures for a chemical, biological, radiological, or nuclear threat, or an emerging infectious disease,” caution must be stressed that the we view the primary purpose of this fund as supporting the immediate scaled up surge needs for the public health and health care response to the affected communities. Inclusion of the aforementioned medical countermeasures provision should in no way detract from this primary purpose nor should it limit or restrict access to needed resources as this pre-approved standing fund of emergency resources should have the primary objective of expediting the *public health response* to disasters.

For example, since there was no functional emergency fund available, during the response to the Zika virus in 2015, Congress was delayed in passing emergency supplemental fund. As a result, the Centers for Disease Control and Prevention (CDC) redirected \$44.25 million of PHEP funds away from local and state health departments to support the national Zika response. As a result, state and local health departments lost, at least temporarily, the resources they needed to effectively respond to Zika and other emergencies at the community level. Additionally, delayed supplemental funding for Ebola impacted state, local and private health systems’ ability to be fully prepared and operational. It is difficult for some health care systems to be prepared for surge during low occurrence, high consequence events. While we are pleased the draft, bill includes language that the fund should supplement and not supplant existing, base public health and preparedness funds; it should also not preclude supplemental emergency funding based on the scope, magnitude and duration of the emergency at hand; and it should come with a mechanism to automatically replenish funds. Such a fund should be used in the short-term for acute emergencies that require a rapid response to saves lives and protect the public.

ASTHO opposes the use of transfer authority to provide funding for an emergency. It is not a matter of if, but when the next disaster or emergency will strike. HHS and other agencies are already historically underfunded and we therefore encourage the committee to consider other funding mechanisms beyond discretionary appropriations or transfer authority. ASTHO is adamantly opposed to any funding

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mechanism that cuts or repurposes existing public health funding for an emergency fund. This emergency fund should be a pre-approved standing resource and could potentially be structured similarly to the NIH and FDA “accounts” established by the 21st Century Cures Act that garnered robust bipartisan support.

ASTHO supports the continuation of the temporary reassignment of state and local personnel through 2023.

Sec. 202: Improving State and Local Public Health Security

The authorization level of \$670 million for PHEP is extremely low. We strongly urge the committee to include an authorization of **\$824 million for PHEP** as this was the original authorization level in the PAHPA legislation of 2006. The most recent appropriation was for \$670 million. Federal funding is crucial to maintaining state, local and territorial public health preparedness capacity. Even small fluctuations in funding—such as the 2016 redirection of \$44 million from PHEP for the federal Zika response—have major impacts on workforce, training, and readiness. These cuts cannot be backfilled with short-term funding after an event. The elevated threat assessment for chemical, nuclear/radiological and cybersecurity, much more work need to be done—and done quickly.

Sec. 203 Partnerships for State and Regional Hospital Preparedness to Improve Surge Capacity

While ASTHO certainly does not object to adding “health coalitions, state hospital associations or a health system” to the list of potential partners, we do oppose any provision that would designate them as an entity that may be eligible to directly apply for HPP funding. One of the most crucial functions of the HPP is to bring together and “incentivize diverse and often competitive health care organizations to work together.” As neutral conveners, state and territorial public health departments are the most appropriate entities and stewards of taxpayer dollars, are responsible for statewide planning and coordination of services, and fundamentally serve all residents of their jurisdictions, not just covered lives, or a specific catchment area.

Moreover, ASTHO urges the committee to include an authorization level **\$474 million for HPP**. This was the original authorization level in the PAHPA legislation of 2006. HPP’s highest appropriation was \$515 million, yet the program has eroded to \$265 million, a vastly insufficient level given the task of preparing the healthcare system for a surge of patients, continuity of operations, and recovery. Again, with the elevated threat assessment for chemical, nuclear/radiological and cybersecurity, much more work needs to be done—and done quickly. We are gravely concerned especially with the increased pool of applicants in conjunction with the low authorization level HPP the foundational capabilities will be further eroded at the state and local level.

Both PHEP and HPP must be resourced at sufficient levels to ensure that every community is prepared for disasters. An efficient and effective state and local workforce depends heavily on reliable, ongoing funding support for a network of state and local expertise, relationships and trust that is carefully built over time through shared responses, training, and exercises. Finally, HPP and PHEP cooperative agreements must continue to fund existing awardees—all states, territories/freely associated states, and

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four directly funded large cities. HPP and PHEP are key to the foundational capabilities of healthcare and public health preparedness, respectively. They are vitally important and distinct programs.

Sec. 301 Strategic National Stockpile and Security Countermeasure Procurement

While ASTHO has not historically taken a position on which federal agencies have oversight of various programs, if the shift of the control and management of the Strategic National Stockpile to ASPR proceeds, we strongly encourage the committee to insert language into statute to maintain coordination and collaboration between ASPR and the CDC.

The role of public health, including the CDC, in the administration of the SNS is critical. The CDC collaborates with state, territorial and local public health departments maintain ties to the communities they serve and are depended upon to deliver the life-saving materiel to their populations. There is no other current entity that has the capacity and expertise in this role. Additionally, public health is a vital partner in devising and implementing the SNS strategy and bringing “boots on the ground” perspective to the more operational role of ASPR. Many of these activities are very closely aligned and often integrated with CDC programs such as PHEP, Emerging Infectious Diseases, Epidemiology and Laboratory Services, Global Migration and Quarantine, etc. necessitating continued collaboration, coordination, and contribution by CDC in the SNS space going forward. In that regard, Congress should require HHS to promptly notify jurisdictions of changes in Strategic National Stockpile (SNS) composition and other factors that impact the ability of jurisdictions to rapidly dispense MCM. We also encourage allowing state and local health departments input into the contents of the materiel in the strategic national stockpile.

ASTHO encourages the Energy and Commerce Committee to include the following provisions:

Codify the Role of CDC to Administer PHEP

ASTHO strongly supports the provision in the Senate Bill S. 2752 Section 202 which clarifies the role of CDC to administer the PHEP Cooperative Agreement Program. We strongly encourage the Energy and Commerce committee to include a similar provision in their draft legislation. State and territories have a long standing and positive relationship with the CDC. The federal, state, and local partnership is critical to ensure a robust public health response to emerging threats, disasters, and emergencies.

Improving efficiency and strategic planning for the use of PHEP and HPP Funds

Several strategies should be implemented to reduce administrative burdens on state public health departments:

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 sector in preparedness.

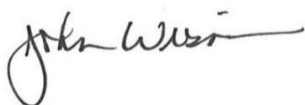
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3. Notwithstanding any existing provisions to the contrary, formally allow state, local, and territorial public health staff funded through federal categorical cooperative agreements and grants to allocate up to 5 percent of their time to participate 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, 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.
4. ASTHO and its members shared with the Senate HELP committee, “the people are the net.” We fear that at this proposed authorization 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 ultimately cost us more in the long run both in dollars and in lives.

ASTHO and our members look forward to working with you and your committee. Please contact Carolyn McCoy, Senior Director of Government Affairs (cmccoy@astho.org) for additional information.



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