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May 4, 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 comments on the discussion draft legislation entitled, "The Pandemic and All-Hazards Preparedness and Advancing Innovation 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 much of the current discussion draft bill retains elements proven to be necessary, reasonable, and successful, and while making further refinements to the underlying statute. In addition, we believe the bill should be improved in the areas including authorization levels, funding for the emergency fund, 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. 101 Strengthening the National Health Security Strategy

- ASTHO supports the inclusion of zoonotic disease and disease outbreaks related to food and agriculture (One Health) because the health of people, animals, plants, and the environment are all deeply connected. This will aid in identifying diseases that affect animals and could impact humans.

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- ASTHO also encourages adding the term “naturally occurring” and changing “environmental health” to “the environment.”
- ASTHO supports the global health security provision included as part of the national health security strategy to assess current or potential health security threats from abroad to inform domestic public health preparedness and response capabilities.
- State and local public health rely on the abilities and competency of federal partners to administer the Hospital Preparedness Program (HPP), the Public Health Emergency Preparedness Program (PHEP) and Strategic National Stockpile (SNS) Program. Therefore, we propose to add “administering federal agencies” in 201(k)(1): “(1) In general.—Not later than 2 years after the date of enactment of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2018, and every 2 years thereafter, the Secretary shall conduct an evaluation of the performance measures and evidence-based benchmarks and objective standards that assess the ability of awardees and administering federal agencies to accomplish the activities described in this section and section 319C–2...”

Sec. 202: Amendments to Preparedness and Response Programs

- ASTHO strongly supports the provision (page 8 line 19) to clarify the role of Centers for Disease Control and Prevention (CDC) to administer the PHEP Cooperative Agreement Program. 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.
- The authorization levels for PHEP and HPP in the discussion draft legislation are blank. PHEP and HPP are key to the foundational capabilities of public health preparedness and healthcare, respectively. These programs must be resourced at sufficient levels to ensure 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. Therefore, we encourage the following regarding authorization levels:
 - **\$824 million for PHEP:** 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. And with the elevated threat assessment for chemical, nuclear/radiological and cybersecurity, much more work need to be done—and done quickly.
 - **\$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 need to be done—and done quickly.

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- Finally, HPP and PHEP cooperative agreements must continue to fund existing awardees –all states, territories/freely associated states, and 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. 203 Regional Public Health Emergency Preparedness and Response Systems

- ASTHO is pleased that this section includes reinforcing language that state, local, tribal, and territorial health leaders assist in the development of guidelines for the regional public health emergency preparedness and response systems.

Sec. 205 Strengthening and Supporting the Public Health Emergency Fund (PHEF)

- ASTHO is extremely concerned about the new provision regarding uses of the fund (page 35 line 19) that the uses of the fund focus on “facilitate coordination,” between and among state and local health departments. In the event of an emergency, these funds must be rapidly deployed to the jurisdictions that are on the front lines and should be at the scale and speed necessary to help save American lives. We strongly encourage the committee to include explicit language under section entitled (2) such as:
 - *Secretary may take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder.*

It is important to note that while under the existing statute this provision is included under the “general” section, however it must be explicit in the bill that emergency funds can be used for grants and contracts.

- ASTHO is also concerned that no funding mechanism exists for the Public Health Emergency Fund. It is not a matter of if, but when the next disaster or emergency will strike. State, territorial, tribal, and local health departments cannot wait for Congress to approve emergency supplemental funding especially with people’s lives at stake. We encourage the committee to consider other funding mechanisms beyond discretionary appropriations or transfer authority. ASTHO is adamantly opposed to any funding mechanism that cuts or repurposes existing public health funding. 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.
- We agree that this fund should serve as a bridge between underlying preparedness funds and supplemental emergency funds. We ask that language be added after line 14 that clarifies such intent: *“Funds appropriated under this section shall be used as a bridge between preparedness and supplemental emergency appropriations and should not supplant other Federal, State, and local public funds provided for activities under this Act, nor should they supplant emergency supplemental appropriations as needed.”*
- It should be clear that the public health emergency fund (PHEF) is an immediate response fund, not a source of funding for long-term, ongoing health threats. We urge you to add language to the “In General” paragraph (42 U.S.C §247d (b)(1)) or a separate “Purposes” section to clarify that the intent of the PHEF is to be used in the short-term for the acute, immediate response to emerging public health emergencies that require a rapid response to save lives and protect the public.

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- **Crisis Funding:** We urge you to add language to this section directing the Secretary to explore and ensure that there are means for funds to be distributed from the PHEF in an expedited fashion. Recently, the CDC issued a [Public Health Crisis Notice of Funding Opportunity](#) to more quickly disburse funds in the event of a public health emergency. The Secretary could be directed to create similar mechanisms as appropriate for other Uses listed in sec. 205.

Sec. 302 Health System Infrastructure to Improve Preparedness and Response

- ASTHO is pleased this provision requires the Assistant Secretary for Preparedness and Response (ASPR) to include logistical support from federal, state, local, tribal, and territorial public health officials to identify the infrastructure entities capable of preparing for, responding to, or mitigating the effect of a public health emergency.
- ASTHO encourages under the Strategic National Stockpile (page 42 line 20) to include a line and under the requirements in statute include the following:
 - Shall establish formal mechanisms to solicit and consider input from state, territorial, local, tribal, and public health officials.

Sec. 402 Public Health Emergency Medical Countermeasures Enterprise (PHEMCE)

The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) strategy and implementation plan should be strengthened by requiring federal partners to routinely solicit and incorporate state and local feedback regarding medical countermeasures to ensure that critical decisions affecting dispensing operations take into account local planning concerns. Without coordination, state and local entities will inevitably face additional hurdles to achieving their missions.

- ASTHO encourages the HELP Committee to include a state 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 PHEMCE membership to ensure 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.
- Moreover, on page 53 line 14 ASTHO urges the HELP Committee to strike the word “consider” and insert “include”. The paragraph should state:

*In carrying out paragraph (1) (C) the PHEMCE shall **include** input from State and local public health departments.*

Sec. 403 Strategic National Stockpile

- 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 medical countermeasures (MCM). We also encourage allowing state, territorial, tribal, and local health departments input into the SNS.

Sec. 701 Reauthorizations and Technical Changes

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

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ASTHO encourages the HELP Committee to consider including the following provisions in the updated draft of the bill.

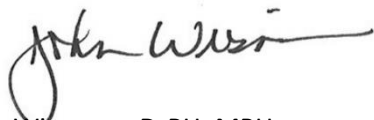
Improving efficiency and strategic planning for the use of PHEP and HPP Funds

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.
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.

We applaud your commitment to the reauthorization of the Pandemic and All Hazards Preparedness Act. ASTHO and our members look forward to working with you and your committee. Please contact Carolyn Mullen, ASTHO, chief of government affairs (cmullen@astho.org) for additional information.

Sincerely,



John Wiesman, DrPH, MPH
ASTHO President, Secretary of Health,
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