March 28, 2023

The Honorable Bernie Sanders
Chair
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

The Honorable Bob Casey
United States Senate
Washington, DC 20510

The Honorable Mitt Romney
United States Senate
Washington, DC 20510

Via email to PAHPA2023Comments@help.senate.gov

Dear Chairman Sanders, Ranking Member Cassidy, Senator Casey, and Senator Romney:

On behalf of the Big Cities Health Coalition (BCHC), I write to provide comment on the Committee's Pandemic All-Hazard Preparedness Act (PAHPA) request for information. BCHC is comprised of health officials leading 35 of the nation's largest metropolitan health departments, who together serve more than 61 million – or about one in five – Americans. Our members work every day to keep their communities healthy and safe. As you well know, PAHPA must be reauthorized to maintain key legal authorities that sustain and strengthen our nation's preparedness for public health emergencies whether man made or naturally occurring.

Role of Big City Health Departments

Big city health departments (including county health departments that serve big cities) are on the front lines of preventing and responding to public health emergencies, including natural disasters (such as fires, floods, and earthquakes), terrorist attacks, and pandemics. Local health departments (LHDs) help to build resilient communities by preparing for, responding to, and supporting residents who are recovering from, public health emergencies.

Public health preparedness at the local and state level is primarily funded through two federal cooperative agreements authorized in PAHPA – the Public Health Emergency Preparedness (PHEP) and the Hospital Preparedness Program (HPP). PAHPA also supports health system preparedness and the development of critical medical countermeasures.

As we saw with the COVID-19 pandemic, our everyday public health systems serve as a baseline level of preparedness for an emergent response. A well-functioning everyday public health system – infrastructure, workforce, disease surveillance, laboratory testing, infection control, and medical countermeasure administration – *is* pandemic preparedness and also must be well resourced by the federal government. As a nation, we are only as prepared as our weakest neighboring community.

Topic I: Public Health Emergency Coordination and Policy

The responsibilities and authorities of the Secretary of Health and Human Services (HHS) prior to or during a public health emergency (PHE)

Public Health Emergency Fund (PHEF)

BCHC supports reauthorizing the Public Health Emergency Fund, which would allow for a fast, flexible, and functional method to quickly provide money to the HHS Secretary as well as to state and local partners. Such funds should be additive, not require jurisdictions to use existing preparedness funds, and should also not rely on CDC to use their own response funds which are primarily used to support internal activities.

Emergency dollars to support a robust response in the intervening time it takes Congress to act are critical. Big cities are often first to respond to crises ranging from hurricanes to outbreaks to floods using whatever dollars are available at that moment, with the expectation that the federal government will contribute to the response. A mechanism to get dollars out quickly to local, state, and federal public health agencies is critical for standing up an emergency response in a timely manner. For example, in the 2016 Zika outbreak it took Congress 233 days to respond to an emergency request from the Obama Administration.

Although funding was quickly provided to some local jurisdictions (largely through cooperative agreements with the states) during the early days of the pandemic response, this was not the case for the mpox outbreaks. Funds were made available to most state and local public health departments well after the outbreak had peaked and response activities were waning. This hindered the ability of jurisdictions to respond in a robust and rapid manner. This emergency fund should be a pre-approved 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.

The PHEF as designed provides no-year money that can be carried over if it is not needed right away; enables HHS to make grants, enter into contracts, and conduct investigations pertaining to public health emergencies; can be used to strengthen biosurveillance and laboratory capacity, including paying for the development of diagnostic tests; can fund the development of emergency medical countermeasures like vaccines and treatments; and can support deployment of response personnel. Such a fund, if resourced, would provide a critical bridge between base preparedness funding and supplementary appropriations for acute emergencies and emerging threats, as well as support a baseline level of routine preparedness.

Given that the fund was originally authorized in 1983 and has not been used since 1993, it is clear that there is an unwillingness to appropriate dollars to it. Therefore, we strongly support creating a trigger mechanism for the PHEF whereby it receives an immediate infusion of resources once a public health emergency is declared. Dollars should not simply be "transferred" from existing public health and preparedness resources into the fund, and it should only be used at the request of governmental public health agencies who are preparing for (or responding to) events whose scale, timing, or unpredictability threatens to overwhelm routine capabilities. There should also be additional triggers for state, tribal, local, and territorial (STLTs) officials to access the fund, such as the discretion of the HHS Secretary combined with other factors, e.g., whether the World Health Organization has declared a public health emergency of international concern or through a "declaration of need" process, not necessarily a formally declared PHE. By including some flexibility into a trigger mechanism, public health authorities could obtain necessary funding, when appropriate, likely in a more timely manner.

Furthermore, under current law, HHS must submit to the authorizing and appropriating committees a report at the end of each fiscal year describing how the Fund was used. BCHC recommends HHS also be required to include in the report information about which entities received dollars through the Fund and what activities the dollars are used for, including any sub-granting of those dollars.

Temporary Reassignment of Federally Funded Staff

BCHC supports reauthorizing temporary reassignment of federally funded staff in the event of an emergency and urges modification to the provision to provide flexibility so local health departments and federal agencies may also issue and receive temporary reassignments. Currently only state governors or tribal leaders are authorized to submit temporary reassignment requests to support a PHE. Expanding that mechanism would enable increased continuity of operations that are vital for a response. As such, we recommend changing the language to enable Public Health Emergency Preparedness (PHEP) Directors to be allowed to submit the request on behalf of the jurisdictions directly to ASPR, not via an elected official. Importantly, the current policy requires the Governor or a designee to submit the temporary reassignment request. We recommend, however, that the PHEP Director of a state/local health department should be able to submit this request, which would shift decision making power to professionals managing the crisis. Finally, we urge Congress to direct HHS to work with its agencies to establish a "one-stop shop" for STLT health agencies to submit emergency reassignment requests. STLT health agencies should not need to repeat the entire process each time the public health agency renews an employee.

Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB)

We support reauthorizing the PACCARB to coordinate federal activities to address antimicrobial resistance (AMR), which continues to be a major threat here in the U.S. and around the world. Effective antimicrobials are critical to our nation's preparedness and are also the foundation of modern medicine, underpinning procedures such as organ transplantation, major surgery, and the care of immunocompromised patients. However, in response to the use of antimicrobials, bacteria and fungi adapt and mutate over time, becoming resistant to treatments. The decreasing effectiveness of antimicrobials caused by rising rates of resistance impedes our ability to respond to any public health emergency. Congress should bolster efforts to protect antibiotics for the nation and globe and require HHS to: (1) Authorize funding for and require the CDC to establish coordinated statewide antibiotic stewardship initiatives, and (2) Authorize funding for efforts to support the interoperability of the National Healthcare Safety Network (NHSN), particularly in order to facilitate hospitals' ability to report AR data. It is impossible to fully understand the full scope of AMR in the US without this data.

The authorities, duties, and functions of the Assistant Secretary for Preparedness and Response (ASPR)

ASPR

BCHC supports authorizing the Administration for Strategic Preparedness and Response as an operating division within HHS to give it more authority over its preparedness and response mission and over its funding for staffing, contracting, and response. We support expanding ASPR's Other Transaction Authority (OTA) to enter into transactions other than contracts, grants, and cooperative agreements for specific circumstances when these mechanisms are not likely to achieve the best result or provide the best value to the government or the public. BCHC also supports providing ASPR with flexible workforce solutions including the ability to directly hire for positions that support and aid preparedness, response, and recovery activities and flexible pay options to waive the overtime pay cap, provide danger pay, and pay over the General Schedule scale.

During the early days of the COVID pandemic, much of what ASPR managed was done with existing Department of Defense (DoD) or Federal Emergency Management Agency (FEMA) contracts and – to some degree – their staff because each had the authorities and mechanism to respond more immediately. ASPR should also be appropriately authorized to do just that rather than depending on other federal agencies.

This PAHPA reauthorization is also an opportunity to improve coordination pathways among federal agencies and between state and local health departments. We need a truly coordinated all of government approach at the federal level that includes not just HHS, but also other departments that interface with jurisdictions on areas key to preparedness. It is essential that federal agencies have clear preparedness and response roles – well in advance of an emergency, and that these roles can be understood at state and local levels for improved coordination, information sharing, and more efficient and streamlined responses. It would be incredibly helpful in the future to have FDA, CMS, ASPR, and CDC all working together to help understand and rapidly solve problems that jurisdictions are reporting.

Strategy for Public Health Preparedness and Response to Address Cybersecurity Threats

BCHC supports a continued focus on cybersecurity threats particularly as it pertains to public health data and entities. Much of the focus to date has been on health care entities, even as several local governments have been victims of cyberattacks over the last five years. Local and state health departments need assistance from the federal government to strengthen their cybersecurity infrastructure and prepare for possible cyberthreats. Cybersecurity efforts should consider the unique needs of health departments at different jurisdictional levels and sizes (i.e., local, state, and territorial), as well as health departments in both rural and urban settings. Cyberattacks have the potential to compromise individual patient records, as well as whole systems that, if compromised, would result in a loss of access to vital services for people who rely on the public health safety net. Ensuring that health departments are prepared for cyberattacks is critical to the mission of protecting and promoting the health and safety of communities nationwide, and we urge you to include public health and health departments in the HHS's cybersecurity initiatives.

The National Health Security Strategy (NHSS)

The NHSS is important to setting preparedness and response strategies for the nation's public health system. BCHC appreciates that the NHSS currently recognizes the importance of developing and sustaining the federal, state, local, and tribal public health capabilities, and ensuring coordination across the public health enterprise. BCHC encourages Congress to also direct the NHSS to ensure coordination across sectors including public health, emergency management, and health care. NHSS describes potential emergency health security threats, and BCHC supports maintaining as a goal preparedness and response related to zoonotic disease, food, and agriculture.

Topic II: Medical Countermeasures (MCMs) Development and Deployment

The Strategic National Stockpile (SNS)

BCHC supports the reauthorization of the SNS as a critical resource to address public health emergencies. BCHC urges you to consider how any changes to the SNS affect the role of STLT public health departments in MCM deployment. SNS deployment is a key capability supported by the PHEP cooperative agreement. CDC works with STLT health departments to develop the capability to receive and distribute countermeasures from the stockpile.

One of the roles of governmental public health has been to gather situational awareness for the demand of MCMs during an emergency so states and locals can request and effectively use products from the SNS. This incident command structure is intended to ensure that supply is meeting demand. If more products are maintained in vendor-managed inventory, clarification is needed on how those products would be distributed to states, and locals wherever possible, in an equitable and efficient fashion and how public health departments would continue to be engaged in the request and receipt of products. CDC must retain its responsibilities of technical assistance, subject matter expertise, and support of PHEP MCMs capabilities, with coordination and support from ASPR staff.

Congress should not only provide sufficient funding for the upkeep of the SNS but also increase transparency as to its contents. Recognizing there is a need to exercise some caution regarding what is in the SNS, there is still some level of information that can and should be shared with state and local partners. Congress should require additional reporting on the status of the SNS, including expenditures and expiration dates of goods, on a regular and timely basis.

The Biomedical Advanced Research and Development Authority (BARDA)
BARDA's mission space has expanded, yet the funding to fight additional threats – from pandemic flu to emerging infectious disease (EIDs) and antimicrobial resistance – remains stagnant. We recommend authorizing separate programs and budget lines for BARDA's work on pandemic influenza, EIDs, antimicrobial resistance, H1N1, Ebola, Zika, and COVID-19. Congress has had to provide supplemental funding for ASPR to take action, including the development of diagnostics, vaccines, therapies, and other related MCMs. It is time for Congress to acknowledge that we must truly be prepared for all hazards and strengthen our armamentarium beyond chemical, biological, radiological, and nuclear (CBRN) threats.

The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) and related strategy, implementation plan, and budget plan

The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) is intended to be an interagency body that oversees decisions on research and development, procurement, and stockpiling of MCMs, as codified in PAHPA. BCHC recommends a permanent seat for STLT public health officials. STLT health officials are responsible for the last mile, getting lifesaving medications to people who need them. The requirement to include representation of STLT public health officials on the PHEMCE is essential and will ensure this critical perspective is included in decision-making related to the SNS products and distribution plans from the beginning. The need for a "boots on the ground" perspective regarding MCMs during the COVID-19 response – and mpox – was apparent, and Congress should codify this representation in the PHEMCE.

Integral to the success of the SNS is an effective interagency process for decision-making about the enterprise. HHS must ensure the PHEMCE continues to lead these key determinations, including what items should be purchased for, and held in, the stockpile, as well as what should be held in vendor-managed inventory, if appropriate. The PHEMCE strategy and implementation should also require that local and state health departments be involved in all phases of the MCMs enterprise including in initial investment; research and development of vaccines, medicines, diagnostics, and equipment for responding to emerging public health threats; and distribution and dispensing of countermeasures.

Topic III: Support for Jurisdictional Preparedness and Response Capacity

The Public Health Emergency Preparedness (PHEP) Cooperative Agreements
The PHEP grant program was created after September 11, 2001 to provide core funding to strengthen local and state public health departments' capacity and capability to effectively respond to public health emergencies, including terrorist threats, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. CDC PHEP grants are provided to 50 states, four localities (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight territories and freely associated states. Most LHDs do not receive funding directly; rather, dollars are meant to be distributed by and through state health departments. As it is often unclear how dollars reach local communities, BCHC recommends Congress request a GAO examining how states determine the appropriate portion of PHEP awards for local health departments and make recommendations on how federal PHEP funds can be more efficiently used to support system wide preparedness.

PHEP funding to grantees has been cut by nearly 30 percent over the last two decades, despite the increase in emerging and re-emerging infectious diseases, and weather-related, environmental, and other emergencies and disasters. The continuous barrage of wide-scale public health emergencies, such as the pandemic and mpox, demonstrates the need to reauthorize and reinvest in these programs to rebuild and bolster our country's public health preparedness and response capabilities. It is not a matter of *if* but *when* the next large-scale public health emergency will occur. The threats are real. As we have seen during the pandemic, public health emergencies have the power to cause human and economic losses not seen in more than a century. Therefore, BCHC recommends that PHEP be reauthorized at $1 billion, which would take into account inflation since the program began and align it with the intended buying power from its 2002 creation of $1.08 billion. The United States needs stronger local, state, federal and territorial public health agencies capable of protecting the health of all Americans in the face of 21st century threats. It is an urgent matter of U.S. national security.

The Hospital Preparedness Program (HPP) Cooperative Agreements
HPP prepares the nation's health care system to save lives during emergencies and disasters. ASPR HPP grants are provided to 50 states, four localities (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight territories and freely associated states. HPP supports regional health care coalitions to incentivize health care readiness, assess risks and needs, train the workforce, and maintain preparedness among organizations that might otherwise see each other as competitors. ASPR data show that approximately 96% of participating hospitals feel that HPP support has improved their ability to decrease morbidity and mortality during disasters. HPP has been cut by more than 50% over the last 20 years and remains stretched due to prolonged emergency responses, increased preparedness and response requirements, and annual discretionary funding not keeping pace with inflation. Therefore, BCHC recommends that HPP be reauthorized at $500 million – the amount grantees received twenty years ago in FY 2003.

Other ASPR activities financed through the general HPP budget, such as the Regional Disaster Health Response System (RDHRS) demonstration projects
BCHC supports reauthorizing the RHCEPRS Program. Regional systems being developed should be complementary to HPP to help build capabilities and capacity across recipients and regions and not remove existing funding and capacity for HPP and its funding recipients.

The Medical Reserve Corps (MRC)
BCHC supports reauthorizing the MRC, a national network of more than 300,000 volunteers in approximately 800 community-based units. In FY2021, MRC volunteers contributed over 2.7 million volunteer hours of service from over 600 MRC units to their communities. HHS has estimated the total economic value of this contribution, which included the efforts of a variety of medical professionals, at over $91 million. BCHC also supports extending MRC liability coverage and providing authority to hire MRC volunteers.

The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP)
BCHC supports the reauthorization of ESAR-VHP administered by the ASPR. The program was created to support locals, states, and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. Working within this network of verified credentials and hospital privileges, volunteers can serve at a moment's notice, within their state or across state lines, to provide needed help during an emergency.

The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement Program and related activities, including mosquito abatement
BCHC supports reauthorization of the ELC grant program that serves as a single vehicle for multiple programmatic initiatives at 50 state health departments, six large BCHC member cities (Chicago, Houston, LA County, New York City, Philadelphia, and Washington, D.C.), Puerto Rico, and the Republic of Palau. ELC provides critical federal support to epidemiologists and laboratory scientists who are instrumental in discovering and responding to various food, water, and vector-borne outbreaks, as well as funding vital improvements in health informatics. Despite ELC's vital role in responding to the pandemic, annual funding levels are not adequate to maintain public health preparedness or address routine challenges.

Furthermore, ELC dollars should be directly sent to big city health jurisdictions so they can support local epi and lab capacity. While federal funds supported more than 90% of state epidemiologists (both in annual appropriations and COVID supplementals) in 2021, they only accounted for about 60% of the staff costs for local epis. This is higher than in years past due to COVID supplementals. Further, where funds are not directly sent to local jurisdictions, states should be made to track and report through CDC how they are sub-allocating funding to the local level, including amount, date funds are made available, and how allocation decisions are made. This information should be shared with Congress and the public for accountability and transparency.

BCHC supports reauthorizing the Strengthening Mosquito Abatement for Safety and Health (SMASH Program. Local mosquito control is critical for addressing and reducing the spread of infectious diseases and is key to a One Health framework to address zoonotic diseases and advance public health preparedness. Local and state mosquito control programs include gathering surveillance data for medical and environmental networks to detect possible outbreaks and managing prevention, public education, and vector control. West Nile, Eastern Equine Encephalitis, chikungunya, dengue, and Zika virus are examples of endemic and emerging mosquito-borne diseases in the U.S. that pose threats to the public's health, but they are not the only ones. Changes to the environment (both built and natural), increased globalization, and other shifts make current mosquito control challenges ongoing and new threats inevitable. Big city health departments have a pressing need for sustainable funding to support mosquito-borne disease surveillance programs, vector control policies, and implement integrated mosquito management programs to benefit or minimize harm to people, domestic animals, wildlife, and the environment.

Biosurveillance and Public Health Situational Awareness
BCHC supports reauthorizing provisions in PAHPA to establish near-real-time electronic nationwide public health situational awareness capability through an interoperable network of systems. Big city health officials rely on information from a number of key sources to create the situational awareness they need to prepare for and respond to a variety of public health emergencies. Biosurveillance supports early detection of disease outbreaks, thus enabling more efficient and effective emergency response. Unfortunately, the system authorized in PAHPA has not been developed. Both biosurveillance and syndromic surveillance must be incentivized with federal guidance and funding. It took CDC a very long time to stand up the latter during the pandemic, using their flu and other similar surveillance systems. Even now, the capacity to do this kind of surveillance at the local and state level varies greatly across the country. Many big city health departments are anxious to implement such a program, but don't have the resources to do so. Outbreaks start local, often in big cities; real-time surveillance programs should not just be left to the states to build and manage but should also be supported with federal funds at the local level.

While Congress provided $40 billion in health information technology for the health care system in the HITECH Act, health departments were not eligible for funds. CDC's Data Modernization Initiative is an important step toward modernizing our public health data infrastructure. Many STLT health departments lack modern data systems and still receive data from health care providers by fax or phone, thus inhibiting their ability to address public health threats in real time.

STLT health departments rely on federal funding and do not have the resources to modernize their data systems without sustained annual investment. It is critical that federal resources reach the local level so that surveillance and reporting systems are strengthened at the community level where outbreaks often start. As such, BCHC recommends at least $7.84 billion over the next five years and sustained annual investments over the next decade to support data modernization throughout all levels of the public health system – federal, state, and local.

Vaccine tracking and distribution
BCHC urges expanding vaccine tracking and distribution beyond pandemic influenza to include other emerging infectious diseases (EIDs). The intent of the tracking was originally to inform federal, state, local, and tribal decision makers during an influenza pandemic. The COVID-19 pandemic and the mpox outbreak has demonstrated the need to expand the provision to include other EIDs.

Topic IV: Gaps in Current Activities & Capabilities

What gaps do you see in the PAHPA framework, or how it has been implemented to date?

Adult Vaccine Infrastructure
As we learned from the pandemic, a comprehensive vaccine infrastructure is needed to immunize all Americans against infectious disease threats. Therefore, BCHC supports authorizing a Vaccines for Adults program, which would support un- or under-insured adults' access to Advisory Committee on Immunization practices (ACIP)-recommended routine and outbreak vaccines at no cost. Such a program is essential for enhancing and maintaining the infrastructure needed for future pandemic response, while also ensuring access to routine vaccines in non-emergencies.

While the existing National Vaccine Program or 317 is a critical support mechanism, it is not sufficiently funded to support vaccination for all uninsured adults. Even with the improvements in access to adult vaccines in Medicare Part D, Medicaid, and CHIP, there are still significant gaps in coverage and infrastructure for adults that leave Americans vulnerable to vaccine-preventable diseases, both routine and emergent.

Disease X

BCHC supports the inclusion of the *Disease X Act* (S. 2640, 117th Congress), which authorizes funding for BARDA for a Disease X MCM program focused on developing responses to unknown viral threats. In establishing a Disease X program, BARDA would coordinate and collaborate with agencies across the PHEMCE. Importantly, a top priority of the Disease X program is equity and accessibility, including ease of administration and distribution. While we don't know what the next pathogen of pandemic potential will be, we do know which viral families are most likely to cause pandemics. COVID-19 vaccines were able to be developed quickly because of the prior 15 years of federal investment in coronavirus research. It is imperative that we start preparing now for what lies ahead.

Seasonal and Pandemic Influenza

BCHC supports inclusion of the *Protecting America from Seasonal and Pandemic Influenza Act* (H.R. 9476, 117th Congress), which builds on the National Influenza Vaccine Modernization Strategy and lessons learned from the COVID-19 pandemic to strengthen the federal government's seasonal and pandemic influenza ecosystem, including flu vaccine innovation, virus detection, and prevention. Each year, seasonal flu kills tens of thousands of Americans – including too many children – and results in hundreds of thousands of hospitalizations and millions of illnesses and missed workdays. Importantly, we must also prepare for influenza strains that have pandemic potential, particularly as there is no commercial market for the development of products to prevent, detect, or treat pandemic flu.

Additionally, aside from currently authorized programs and activities, what gaps exist in HHS' capabilities, and what types of activities or authorities are necessary for HHS to fulfill the intent of PAHPA and related laws?

Public Health Data

BCHC supports inclusion of the Improving *Data Accessibility Through Advancements in Public Health Act* or *Improving DATA in Public Health Act* (H.R. 5376, 117th Congress) that promotes coordination between federal agencies to share critical public health data used to prepare for and respond to public health emergencies. The bill also creates standards to improve and secure the transfer of electronic health information and establishes an Advisory Committee to ensure that public health data reporting processes are carried out effectively. Every effort must be made to strengthen public health data systems as an essential component of emergency preparedness.

BCHC also supports giving CDC the authority to effectively collect and coordinate public health data necessary to serve its mission and address known blind spots. The current framework for collecting and sharing public health data has resulted in fragmented and inconsistent reporting to CDC, and to state and local public health partners. Expanded data authority for CDC will allow for more complete and timely data sharing to support decisions at the federal, state, and local levels, while reducing burden on providers. For example, authority included in the CARES Act requiring COVID-19 laboratory test reporting during the PHE greatly improved the availability of laboratory data. We support CDC having the authority to require reporting of minimum necessary data to serve a range of public health and other mission-critical use cases.

Hiring Authorities and Flexible and Overtime/Danger Pay

In addition to providing ASPR greater hiring authorities and flexibility, BCHC urges that CDC also be afforded the needed authorities to align with the expectation of CDC being a response agency. CDC should also be given the authority and flexibility to direct hire for positions that directly support and aid preparedness, response, and recovery activities. This would support a nimble response that can quickly surge to address an emerging threat. In addition, it would allow the agency to non-competitively hire term employees in certain circumstances.

CDC should also be given flexibility to pay over the salary caps. This authority would allow CDC to establish a flexible pay scale for priority positions, hire surge staffing and pay surge personnel above the GS scale during a declared PHE, similar to other response agencies like FEMA. Similarly, the agency should be afforded an overtime pay cap waiver and the ability to provide danger pay for certain roles. This would allow CDC to appropriately compensate those staff who are responding at a moment's notice and/or being put in harm's way. Finally, federal action on these challenges would also support local and state health departments' attempts to get these authorities - particularly overtime in an emergency - from their local elected officials or governing entities.

Public Health Ready Response

CDC should be given the authority to use appropriated funds to support a cadre of response-ready staff in each of CDC's 13 different budget accounts. These staff could deploy for any PHE or an event with significant potential to become an emergency. Further, the CDC director should be given the authority to dedicate up to 1% of each account for the purpose of funding these long-term, response-ready detailees/deployments. Such authority would not only enable CDC to stand up an emergency response, but also support the local and state health departments in standing up their response. BCHC urges flexibility with this funding to enable deployment of CDC staff expeditiously.

Direct Transfer Authority

To be a response ready agency, CDC should be given the authority to, when necessary, transfer a small proportion of funds from existing budget accounts to provide the CDC Director with modest flexibility to rapidly address new or emerging problems before they escalate. This flexibility could also help CDC provide flexibility to local and state health departments to scale up a rapid response that is currently hindered by disease-specific funding.

Supply Chain and Critical Physical Infrastructure Authority

HHS should be given the authority to construct or alter non-federally owned facilities, as needed, to support public health requirements (e.g., laboratories, manufacturing facilities). CDC has limited authority to help local and state health departments meet their physical infrastructure needs. Supporting physical infrastructure improvements, in particular improvements to public health laboratories, as an allowable use of funds will enhance local and state preparedness and response. Further, these allowances should be passed on to local and state health departments to allow them to use federal funds to build public health labs, clinics, and other mission critical assets.

Topic V: Partnerships

What specific steps could Congress take to improve partnerships with states and localities, community-based organizations, and private sector and non-government stakeholders, such as hospitals and health care providers, on preparedness and response activities?

Grants for STLT Governmental Public Health Agencies

Effective public health response depends on action at the federal, state, tribal, local, and territorial levels of government. As CDC supports STLT readiness and response, explicit authority to direct funding to governmental agencies at all levels of government is needed. Updated authority would improve the timeliness of awards intended specifically for state and local government jurisdictions. Any such authority should also include an analysis of efficiency and efficacy of dollars getting local through grants to states.

Further, CDC should be encouraged to broaden its direct grantmaking pool to include, at a minimum, the 107 jurisdictions recently funded under the Public Health Infrastructure and Grant Program. This universe of grantees includes the 50 states and Washington, D.C.; eight territories/freely associated states; and 48 local health departments that either serve cities with a population of at least 400,000 or counties with a population of at least 2,000,000 based on the most recent U.S. Census numbers.

Congress should also include the following strategies to reduce administrative burdens on STLT public health agencies for non-emergency federal funds:

- Multi-year funding awards with 24-month budget periods and the ability to redirect funds during the budget period. This would reduce the administrative burden of processing carryover and no-cost extension requests.
- Notwithstanding existing provisions, formally allow STLT public health staff funded through any federal categorical cooperative agreements and grants to adopt federal teleworking rules and standards with approval from the STLT public health authority.

BCHC lauds your leadership in seeking to strengthen the nation's preparedness and response capabilities at the local, state, and federal level. Please do not hesitate to contact me at juliano@bigcitieshealth.org if we can be of further assistance.

Sincerely,

Chrissie Juliano, MPP
Executive Director