July 10, 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 Pandemic All-Hazard Preparedness Act (PAHPA) reauthorization discussion draft released July 3rd. 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. We appreciate your and the Committee's efforts to reauthorize PAHPA to maintain the key legal authorities that sustain and strengthen our nation's preparedness for public health emergencies whether man made or naturally occurring.

BCHC's comments on the discussion draft are below.

*Sec. 101. Public Health Emergency Preparedness program.*

BCHC supports the reauthorization of the PHEP program and the inclusion of pandemic response planning as a PHEP grantee responsibility to reflect the need to plan for pandemics beyond influenza.

In addition, BCHC recommends:

- 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. 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 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.

- 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. Most local health departments do not receive funding directly; rather, dollars are meant to be distributed by and through state health departments. It is often unclear how dollars reach local communities.

*Sec. 103. Improving medical readiness and response capabilities.*

BCHC supports the reauthorization of the HPP program. The draft creates an additional criterion (C) for eligibility for healthcare preparedness cooperative agreements and grants. It is unclear whether this additional criterion, as drafted, would prevent state and local public health departments from administering healthcare preparedness cooperative agreements and coordinating preparedness efforts with healthcare partners in the jurisdiction. State and local public health departments provide essential leadership and serve as a neutral arbiter in the administration of healthcare preparedness cooperative agreements to ensure the preparedness of all sectors of the healthcare system – from academic medical centers, safety net hospitals, to community health clinics and pharmacies. It is critical that the role of public health in the healthcare preparedness enterprise not be diminished.

BCHC also recommends:

- HPP be reauthorized at $500 million – the amount grantees received twenty years ago in FY2003. 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.

*Sec. 104. Pilot program to support State medical stockpiles.*

BCHC supports reauthorizing the pilot program to support state stockpiles. BCHC supports the addition of coordination with other entities within the state or across states such as local health departments. Coordination with local health officials is as critically important for those of our members that maintain their own stockpiles as well as those who don't.

*Sec. 105. Enhancing domestic wastewater surveillance for pathogen detection.*

BCHC lauds the inclusion of awards to state, tribal and local health departments for wastewater surveillance of infectious diseases. Our members have embraced this important disease detection tool working in collaboration with their local water authorities. The discussion draft does not include an authorized funding amount for this program. It is critical that sufficient authorization level be provided to the Wastewater Surveillance System program to realize an effective, nationwide system, and that this authorization is in addition to the existing Epidemiology and Laboratory Capacity (ELC) funding authorization; not a component thereof. As to reporting requirements, we would encourage that CDC consult with local health departments on the data to be collected across jurisdictions, what data are publicly available and by whom they are made available.

*Sec. 106. Reauthorization of Mosquito Abatement for Safety and Health program.*

BCHC supports reauthorizing the SMASH Program and supports the use of grant funds for training and support of public health entomologists. 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, Zika virus, and malaria are examples of endemic and emerging mosquito-borne diseases in the U.S. that pose threats to the public's health. 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**.**

*Sec. 202. Strategic National Stockpile and material threats.*

BCHC supports the enhanced transparency of SNS processes and operations. It is critical that public health stakeholders – including state, local, and tribal governments – know what to expect in a crisis. These stakeholders must know what SNS assets are available, how they will be distributed, and the status of the distribution so they can properly prepare for and respond to public health emergencies.

Local health departments still seek clarity on the defined roles between ASPR and CDC in administering the stockpile and providing support to jurisdictions. There is also a critical need to focus, understanding and communication around the supply chain and demand for these products, which has led to competition for limited resources amongst the response partners. Local public health officials need to be engaged in the communication and administration of these planning efforts.

*Sec. 203. Medical countermeasures (MCM) for viral threats with pandemic potential.*

BCHC supports the authorization of MCM development for viral threats with pandemic potential. It is important that there is dedicated funding for BARDA to carry this out. BARDA has had to rely on supplemental funding to develop MCMs for emerging infectious diseases. BCHC recommends:

- Amending the language in F (ii) to add an additional subsection to say threats that— "include priority virus families and other viral pathogens with a significant potential to cause a pandemic." This will ensure that BARDA is able to engage in MCM development for unknown viruses with pandemic potential and not just those that consistently exit or continually circulate.

*Sec. 204. Public Health Emergency Medical Countermeasures Enterprise (PHEMC).*

BCHC lauds the inclusion of language to allow information sharing with state, local and tribal public health departments. BCHC recommends:

- A permanent seat for state, local and tribal public health officials who are responsible for the last mile, getting lifesaving medications to people who need them. Adding a permanent seat on the PHEMCE and will ensure this critical perspective is included in decision-making related to the SNS products and distribution plans from the beginning. 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. 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.

*Sec. 205. Pilot program for public health data availability.*

BCHC appreciate the inclusion of the public health data pilot program as a first step in strengthening public health data availability. However, BCHC urges the inclusion of the *Improving Data Accessibility Through Advancements in Public Health Act* or *Improving DATA in Public Health Act* (H.R. 3791) 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.

*Sec. 502. Temporary reassignment of State and local personnel during a public health emergency.*

BCHC supports reauthorizing temporary reassignment of federally funded staff in the event of an emergency. BCHC recommends:

- Modifying 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 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.

- Directing HHS to work with its agencies to establish a "one-stop shop" for state, local and tribal health departments to submit emergency reassignment requests. Health departments should not need to repeat the entire process each time the public health agency renews an employee.

*Sec. 503. Vaccine tracking and distribution.*

BCHC supports the reauthorization of vaccine tracking and distribution and further 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.

*Sec. 504. Regional health care emergency preparedness and response systems (RHCEPRS).*

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.

*Sec. 505. Emergency system for advance registration of volunteer health professional (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.

*Sec. 510. Volunteer Medical Reserve Corps (MRC).*

BCHC supports the reauthorization of 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.

*Sec. 511. Epidemiology-laboratory capacity (ELC) grants.*

BCHC supports the reauthorization of the ELC grant program that serves as a single vehicle for multiple programmatic initiatives at state and local health departments. 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.

*Public Health Workforce and Infrastructure*

Further, while the PAHPA reauthorization draft contains many critical provisions, the discussion draft does not provide sufficient support to rebuild and expand the nation's public health and health care workforces. Along with the ongoing shortage of healthcare workers, persistent cuts to public health funding over the past decade have drastically shrunk the local public health workforce, contributing to a national crisis. BCHC highlights the importance of authorizing and investing in the governmental public health workforce and infrastructure that is critical to being response ready for everyday public health challenges and the next large-scale public health emergency. The *Public Health Infrastructure Saves Lives Act (S.1995)* would establish a Core Public Health Infrastructure Program at the Centers for Disease Control and Prevention (CDC), awarding grants to state, local, tribal and territorial health departments to ensure they have the tools, workforce, and systems in place to address existing and emerging health threats and reduce health disparities.

BCHC also recommends:

- Increases funding authorization levels for existing public health and healthcare workforce loan repayment programs.

- Further investments in critical public health workforce development programs, particularly at CDC, including: Epidemiology Investigation Service (EIS), Career Epidemiology Field Officer (CEFO) program, Laboratory Leadership Service, Public Health Informatics Scholarship, Public Health Associate Program (PHAP) and Preparedness Field Assignee Program (PFA).

*Adult Vaccine Program*

In addition, a comprehensive vaccine infrastructure is needed to immunize all Americans against infectious disease threats. PAHPA should authorize a Vaccines for Adults program, which would support 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 and underinsured 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.

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