American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

March 13, 2023

The Honorable Richard Hudson
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna G. Eshoo
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Hudson and Eshoo:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Request for Information (RFI) on the reauthorization of the Pandemic and All-Hazards Preparedness Act (PAHPA).

Reauthorizing PAHPA is an opportunity to improve our nation's preparedness and response capabilities and capacities, as well as to ensure that the nation's preparedness programs are properly funded, sustained and improved. Although the nation's hospitals and health systems have always played a critical role in responding to all types of disasters and public health emergencies (PHEs), the COVID-19 pandemic has tested our nation more than any crisis in the past 75 years. Indeed, the health care system, with America's hospitals and health systems at the center, met the challenges posed by the pandemic and saved countless lives with skill, compassion and often great personal sacrifice on the part of the health care workforce.

The recent decision to sunset the COVID-19 PHE declaration is a testament to the progress we have made. However, during this transition, it is critical that we commit to building on the lessons learned and the advancements in care delivery and access made during the PHE. While we recognize that this RFI is only the first step in a longer process to reauthorize PAHPA, the AHA is pleased to share our initial recommendations for creating a more effective and stable health care system. Specifically, we urge Congress to, among other actions:

- **Authorize PAHPA's Hospital Preparedness Program (HPP) at a significantly increased level, including additional dedicated, direct-to-hospital-funding that will supplement current investments and allow hospitals and hospital associations, such as academic medical centers,**

health systems and state and metro hospital associations, to compete to be the HPP recipient for their jurisdictions;
- **Use the PAHPA reauthorization to strengthen the Strategic National Stockpile (SNS);**
- **Require the federal government to collaborate with a range of stakeholders to build out a national data infrastructure capable of efficiently sharing important public health information among providers and federal and state agencies; and**
- **Require the Administration to make critical updates to the Department of Health and Human Services' emergency preparedness playbook.**

More details on our recommendations for these and other issues follow.

HOSPITAL PREPAREDNESS PROGRAM

The Hospital Preparedness Program Should Be Authorized at a Significantly Increased Level.

When a disaster strikes, people turn to hospitals for help. Congress recognized this role by creating the HPP in PAHPA. However, the HPP is the only federal funding mechanism for health care system emergency preparedness and response. Since 2002, it has provided critical funding and other resources to aid the health care system response to a wide range of emergencies via cooperative agreements with 62 health departments in all states, U.S. territories and in four cities. The HPP supported enhanced planning and response; facilitated the integration of public and private-sector emergency planning to increase the preparedness, response and surge capacity of hospitals; and improved state and local infrastructure to help health systems and hospitals prepare for PHEs and other disasters. These investments contributed to saving lives and reducing the impact of emergencies and disasters, particularly for localized events.

However, the HPP's funding has not kept pace with the ever-changing and growing threats faced by hospitals, health care systems and communities. Indeed, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. The HPP's highest level of appropriation was $515 million in fiscal year (FY) 2003, yet the program funding has fallen to only $305 million in FY 2023. This is a vastly insufficient level given the expected responsibilities of preparing the health care system for a surge of patients, continuity of operations and recovery during an emergency. The HPP's authorized funding limits also have declined over time, from a high of $520 million in FY 2003, to $385 million in the most recent reauthorization in FY 2018. Additional and sustained funding will be necessary to not only restore HPP to its original capacity, but also to strengthen the program to address increasing threats to public health. One needs to look only at the tremendous strain that the COVID-19 pandemic placed on the nation's health care system to understand why additional support for healthcare preparedness and response is needed.

The HPP should be authorized at a significantly increased level. As such, we urge that the program's authorization be at least doubled for FYs 2024 through 2029. This investment will help prepare and equip our nationwide health care system in advance of the growing number and scope of future disasters and PHEs.

Among Growing Threats, Additional Dedicated HPP Funds Should be Authorized for Hospitals and Health Systems. Over time HPP has broadened its focus and its funding beyond hospitals to other response partners. In particular, the vast majority of HPP funds (nearly 80% in 2023) supports the sub-state Health Care Coalitions (HCCs) – regional collaborations between health care organizations, emergency management, public health agencies and other private partners. While HCC funding supports regional partner coordination and collaboration in advance of and during local emergencies, the result is that only a fraction of the HPP funds is directly provided to hospitals and health systems to support their preparedness and response activities. Currently, the primary HPP investments directed to hospitals to support health care readiness are funding for the Regional Emerging Special Pathogen Treatment Centers (RESPTCs), Special Pathogen Treatment Centers and the Regional Disaster Health Response System (RDHRS). These programs have demonstrated the substantial opportunity that direct funding of hospital and health system partners can provide in improving regional disaster response.

The AHA recommends that PAHPA include in the HPP additional dedicated, direct-to-hospital-funding that will supplement (and not supplant) current investments. Such dedicated funding will help rebuild the program from years of underfunding and provide additional resources to hospitals and health systems to improve their preparedness, taking into consideration the lessons learned from the COVID-19 pandemic and other recent emergencies and disasters.

Broadening the Definition of Eligible Awardees for the 62 HPP Cooperative Agreements. The AHA has long supported introducing competition in determining which entities become the HPP's cooperative agreement recipients. **Specifically, we recommend that hospitals and hospital associations, such as academic medical centers, health systems, and state and metro hospital associations, also be permitted to compete to be the HPP recipient for their jurisdiction, in addition to the current state, territorial and city health department recipients.**

This competition would provide the Administration for Strategic Preparedness and Response (ASPR) with the opportunity to fund those entities that present the most innovative approaches to health care delivery system readiness. As evidence that the entities we cite can be prepared and capable of administering HPP funds, we note that

ASPR successfully distributed $175 million in emergency supplemental funds[1] to hospital associations in all 50 states, the District of Columbia, New York city and Puerto Rico in order to support the preparedness and response activities and needs of hospitals, health systems and health care providers on the front lines of the COVID-19 pandemic.

A second benefit of introducing competition is the potential to address the misalignment between HPP's health care mission and its current recipients' public health mission. While most of the HPP's public health department recipients work well with their private-sector health care delivery system counterparts to enhance preparedness and response, others struggle to work collaboratively with the private health care system that they also regulate. Through this recommendation, certain private health care entities and hospital associations that have the organizational capacity and initiative to lead sector-wide preparedness and response activities also would be able to compete for HPP funds for their state or jurisdiction.

STRATEGIC NATIONAL STOCKPILE

Throughout the COVID-19 pandemic, but especially in its first months, hospitals, health systems and other health care providers experienced severe shortages of essential personal protective equipment, drugs used in critical care, ventilators and other vital products and supplies, resulting in desperate efforts to acquire products necessary to provide care to a surging number of critically ill patients and to protect the hospital workforce and visitors. Many providers turned to stockpiles in their state as well as to the federal SNS, to little avail. Unfortunately, state and federal stockpiles were not designed to provide sufficient resources to support an extended duration and nationwide emergency, like the COVID-19 PHE. Health care providers, distributors and manufacturers, reliant on just-in-time inventory management systems, were not able to keep up with the demand, particularly in the face of a global pandemic resulting in world-wide disruptions in the supply chain. Moreover, over-reliance on foreign producers of essential drugs, devices and other supplies, and inadequate domestic production of these supplies, left the United States unable to quickly ramp up production.

The AHA recommends that the PAHPA reauthorization legislation take a number of steps to strengthen the SNS. First and foremost, it should ensure that the level of authorized funding for the SNS is adequate to guarantee it contains drugs, supplies and equipment that are appropriate in type, condition and amount to serve the nation's needs for as long as possible, but certainly until manufacturers are able to increase their production to meet increased demand. Adequate funding involves ASPR being able to plan for SNS inventory that considers a wide variety and duration of possible PHEs.

---

[1] Via the Coronavirus Preparedness and Response Supplemental Appropriations Act and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

Second, it is critical that health care providers have access to information to understand what products are contained in the SNS, in what amount and how to request and receive SNS supplies. PAPHA should instruct ASPR to develop an easy-to-understand and real-time system to accomplish this. Finally, to protect against expiration and loss of use of SNS supplies, which may be stored for long periods of time, ASPR should employ a vendor-managed inventory system that rotates supplies into the commercial market before they expire, while at the same time purchasing replacement supplies.

OTHER ISSUES

Hospital Data Reporting**.** Hospitals and health systems support the collection and reporting of data that meaningfully informs decisions related to the nation's health and well-being. However, the approach to collecting COVID-19 data exposed myriad challenges, including extremely burdensome requests during a time when all available personnel were responding to an evolving situation at the local level, as well as excessively punitive consequences for failure to report. Some of these data reporting requirements persist; however, the end of the PHE marks an appropriate time to rethink the data collection strategy for the future, with a focus on automation as the goal to reduce the previously mentioned burdens.

To that end, the AHA recommends that PAHPA require the federal government to collaborate with a range of stakeholders – hospitals and health systems, state and local public health agencies, electronic health record (EHR) vendors and others – to build out a national data infrastructure, for all hazards (hurricanes, wildfires, tornadoes, etc.), not just pandemics, that is capable of efficiently sharing important public health information among providers and federal, state and local agencies. The goal of this infrastructure should be to identify potentially relevant technical standards, articulate a process that could be activated in future emergencies and support all stakeholders in preparing for and executing on the approach. **In future emergencies, we also urge that the federal government engage and seek input from hospitals and others in the health care field on the meaningfulness of specific data elements and articulate transparently how any collected data are being used to inform a federal response. We are committed to working with you on continuing to invest in real-time data available to the federal, state and local governments to ensure we are equal partners in providing insight into where patients will have the most efficient access to care.**

Update HHS' Emergency Preparedness Playbook. Currently, the Centers for Medicare & Medicaid Services (CMS) emergency preparedness conditions of participation exist for hospitals and health systems, but COVID-19 demonstrated that the current emergency preparedness framework for our national health care delivery infrastructure is insufficient for effectively responding to a national PHE of this scale.

In general, the national emergency preparedness plan anticipates emergencies of limited size and duration in a community, such as a hurricane, earthquake or mass casualty event. Similarly, many hospital plans and drills were built around responding to such scenarios. While such emergencies are far more common than all-encompassing nationwide emergencies, the challenges of a broader, longer-lasting emergency such as a pandemic necessitate planning for and practicing responses to such events. Most importantly, broad-scale emergencies and long-duration emergencies require connections and collaborations that far exceed those used in more localized, time-limited emergencies. That collaboration creates and fosters the opportunity to use the strengths of health care systems and the experiences of practitioners on the front line to inform other clinicians across the country in ways that would not be needed in a more localized emergency.

The AHA believes that HHS' plans for responding to a national emergency need to be rethought and better coordinated with state-level partners, as well as with organizations that will be key to an effective national response, including hospitals. For example, this coordination could help ensure the SNS is re-designed to provide sufficient backup during an event like the COVID-19 PHE. It also could be used to help ensure that the Centers for Disease Control and Prevention's (CDC) plans for managing the distribution of information and critical supplies, like vaccines and therapeutics, extend beyond the focus on distributing the vital resources to the state, and ensure follow-through to the point of ensuring safe administration to intended recipients. **These issues and others require serious thought and attention, and we encourage Congress to require the Administration to consider and address them in an updated HHS emergency preparedness playbook.**

We describe two specific recommended planning updates below.

Plan for the Unwinding of any Enduring PHE. For hospitals and other health care organizations across the country, the pandemic created many opportunities to learn how to treat patients in innovative ways, to deepen caregiving relationships with patients with chronic conditions and to learn to use new drugs and devices. Regulators waived some of the usual requirements to allow hospitals and other health care organizations to care for as many people as possible. Clinicians used this flexibility and their own ingenuity to accommodate COVID-19 protocols, to address the overwhelming need for beds and breathing assistance and to continue to manage patient care regardless of supply chain shortages. As a result, regulators and clinicians have found some of this innovation to be so helpful to patients and effective in providing needed care that they believe it should be made permanent. Yet, statutory and regulatory barriers do not enable us to effectively and thoughtfully wind down the pandemic changes over time or move to establish the changes permanently where appropriate without engaging in lengthy processes to change laws and regulations.

Through PAHPA, a structure should be set in place by which Congress and the relevant federal agencies, acting on the advice of clinicians, health care organization leaders, patients and families and other interested stakeholders, can identify which changes should be kept and which should be brought to a swift end when the situation allows. **Just as we need a plan for responding to a large-scale emergency, the AHA recommends that Congress should require in PAHPA the development of a playbook for the unwinding of the emergency.**

Using Simulations to Prepare for Unfamiliar Tasks. In many types of emergencies, but especially a pandemic, it is likely that new medications, vaccines or other medical countermeasures will be developed and distributed to impacted populations; yet, the process for doing so may well be difficult to manage. For example, the distribution of the first COVID-19 vaccine included some unique and very specific requirements, such as rules for ultra-cold storage.

CDC developed a playbook and conducted simulations for the distribution of these vaccines with the state public health authorities and its distributor, AmeriSource Bergen, but the agency did not include the hospitals and clinics that would be receiving and administering the vaccines. As a result, there was confusion that either limited the effectiveness of the vaccine or required that doses be discarded at a time when vaccines were in short supply. In fact, hospitals report that during the COVID-19 PHE, they sometimes received pallets of federally purchased and state distributed countermeasures and other supplies in their loading docks without notice.

These situations might have been avoided had the plans and simulations been developed and carried out to include the hospitals and clinics. Such simulations are effective for identifying vulnerabilities in any process, but particularly in hard to manage and difficult to execute operations. **The AHA recommends that PAHPA require the playbooks and simulations for such complex processes explicitly include this type of a comprehensive approach.**

Plan to Take Advantage of Multistate Care Delivery Organizations. The current emergency preparedness plans and playbooks call for health care delivery interactions to run from the federal agencies to the states, and from the states to the hospitals within those states. However, for large health systems that stretch across multiple states, this means that there are differences in policy and protocol based on the state in which an individual hospital is located. This causes problems for the health systems that are then forced to follow different rules for operations from state to state. Further, it hinders their ability to have a uniform and efficient approach to care delivery across their enterprise and diminishes their ability to be part of a more systemic response to a danger such as COVID-19. **The AHA recommends that PAHPA allow the federal agencies to work directly with large health care delivery organizations, as it did with CVS and Walgreens during the COVID-19 PHE, for example, to administer vaccines and therapeutics.**

We thank you for the opportunity to submit comments on the PAHPA reauthorization RFI and look forward to continuing to working with you on this important legislation. Please contact me if you have questions or feel free to have a member of your team contact Megan Cundari, AHA's director for federal relations, at mcundari@aha.org.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President of Advocacy & Political Affairs