American Hospital Association

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June 6, 2018

The Honorable Susan W. Brooks
United States House of Representatives
1030 Longworth House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
United States House of Representatives
241 Cannon House Office Building
Washington, DC 20515

Dear Representatives Brooks 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 Energy and Commerce Committee Subcommittee on Health's discussion draft, titled the "Pandemic and All-Hazards Preparedness Reauthorization Act of 2018."

We appreciate the Subcommittee's willingness to engage stakeholders as the work toward reauthorizing the Pandemic and All-Hazards Preparedness Act (PAHPA) proceeds. Our member hospitals and health systems play a critical role in all types of disasters and public health emergencies, and we share the Subcommittee's goal of improving our nation's preparedness and response capabilities and capacities. In light of our shared goals, the AHA offers the following recommendations regarding the PAHPA reauthorization discussion draft.

SEC. 202. AMENDMENTS TO PREPAREDNESS AND RESPONSE PROGRAMS

The Hospital Preparedness Program Should Be Authorized at a Sufficient Level. America's hospitals and health systems play a critical role in disasters and public health emergencies. Congress recognized that role in PAHPA by creating the Hospital Preparedness Program (HPP), the primary federal funding mechanism for health care system emergency preparedness. Since 2002, the HPP has provided critical funding and other resources to aid hospitals' response to a wide range of emergencies. These investments have contributed to saving lives during many disasters and emergencies.

However, funding for the HPP has not kept pace with the ever-changing and growing threats faced by hospitals, health care systems and their communities. Indeed, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. In particular, HPP's highest level of appropriation was $515 million, yet program funding has eroded to only $265 million, a vastly insufficient level given the task of preparing the health care system for a surge of patients, continuity of operations, and recovery.

The lessons of the many catastrophic emergencies and disasters in 2017 alone – including the hurricanes in Texas, Florida and Puerto Rico, the mass shooting in Las Vegas and the wildfires in California – as well as the threats posed by possible chemical, biological (including emerging infectious diseases), radiological and nuclear events support the need for a much more significant investment in health care system preparedness. Other threats continue to challenge the nation –currently, America's health care system is again focused on the issue.

We are, therefore, extremely concerned that the Subcommittee has proposed an annual HPP authorization of only $264.6 million, a significant reduction from the program's current authorized funding level of $374.7 million and an amount we believe will be inadequate to ensure that the health care delivery system is ready to respond to the ever-changing and growing threats that hospitals, health care systems and communities face. **Instead, we urge the Subcommittee to increase the HPP's authorization level to at least $515 million for each of fiscal years 2019 through 2023, an amount representing a more appropriate level of investment in emergency preparedness as threats and risks continue to emerge.**

We note that the Subcommittee's discussion draft would expand the scope of the HPP beyond preparedness to include response activities, including medical surge for public health emergencies. Further, Sec. 401 of the draft would expand the activities for which the HPP awardees would be responsible to prepare and respond to include cybersecurity threats. **We believe that $515 million in authorized funding for HPP would better reflect Congress' commitment to funding this expansion in scope.**

Broadening the Definition of Eligible Awardees under the HPP. **The AHA supports the Subcommittee's intention to broaden the types of entities that would be eligible to be HPP awardees to include health systems, state hospital associations and health care coalitions.** We believe that introducing such competition into determining HPP's awardees would permit the Assistant Secretary for Preparedness and Response (ASPR) to fund innovation and improve the nation's health security. **We urge the Subcommittee to also explicitly include academic medical centers and metropolitan and regional hospital associations as entities that would be permitted to compete to be the awardee for their jurisdiction.** Doing so will allow the HPP to award funds to those entities that present the most innovative approaches to health care delivery system readiness in their communities. A second benefit of introducing competition is the potential to address the misalignment between HPP's health care mission and its current awardees' public health mission. While most of the HPP's public health department awardees 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 change, private health care entities hospital associations; and health care coalitions that have the organizational capacity and initiative to lead sector-wide preparedness and response activities would also be able to compete for HPP funds for their state or jurisdiction, not just health departments.

Therefore we recommend that text on page 12, line 19-20 be amended to read: "be a health coalition, State, regional or metropolitan hospital association, academic medical center or a health system; and".

However, we are concerned that, although the Subcommittee's purpose seems to be clear, the actual amendments made to Sec. 319C-2(b)(1)(A) include drafting errors that render the section unclear. **In addition to the expanding the competition to academic medical centers and metropolitan and regional hospital associations, the AHA urges the Subcommittee to review and correct the amendments made on page 12, lines 12-20 in the discussion draft to ensure that the intentions are unambiguous.**

In particular, we believe that the following changes may be called for on page 12:

- Line 12, change "Section 319C-2(b)(1)(A)" to "319C–2(b)(1)(A)(iii)".
- Line 15, change "(ii)" to "(II)"
- Line 16, change "(iii)" to "(III)"
- Line 19, change "(iv)" to "(IV)"

Preparedness Programs Should Remain Distinct. The HPP and the Public Health Emergency Preparedness Program (PHEP) should continue to be aligned and coordinated but should be maintained as separate, distinct programs. The two programs serve a different but complementary purpose. PHEP, administered by the Centers for Disease Control and Prevention (CDC), builds the capacity of state and local health departments to prevent, detect and respond to emergencies. HPP, administered by ASPR, prepares the health care delivery system to provide essential care to patients by ensuring surge capacity and continuity of care during disasters. Both programs are needed to save lives and protect the public from emergency-related illnesses and injuries, and each should remain under the jurisdiction of the agency that currently oversee its administration.

We urge the Subcommittee to amend the discussion draft to formalize ASPR's relationship to the HPP and the CDC's relationship to PHEP by amending Sec. 319C-2 and Sec. 319C-1 to ensure that each program remains under the authority of its respective agency. Such language was included in S. 2852, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2018 (PAHPAI), approved by the Senate Health, Education, Labor and Pensions (HELP) Committee.

SEC. 201. PUBLIC HEALTH EMERGENCIES

Sec. 201 amends the authorities of the Public Health Emergency Fund to rename it to the "Public Health Emergency Response Fund" and specifies uses for the fund. It also would permit the Secretary to transfer to the fund up to one percent from any discretionary appropriations.

The AHA supports the concept of a pre-approved standing fund of emergency resources that would speed the public health response to disasters. We support the following principles for such an immediate response fund for public health emergencies. Such a fund should:

- supplement and not supplant existing, base public health and preparedness funds;
- not preclude supplemental emergency funding based on the scope, magnitude and duration of the emergency at hand;

- come with a mechanism to automatically replenish its funds;
- be used in the short-term for acute emergencies that require a rapid response to saves lives and protect the public; and
- be administered by the Secretary of Health and Human Services (HHS), with congressional oversight, to ensure relevant agencies receive dollars when needed for response.

That said, we have concerns about the fund as described in the discussion draft. **First, we are opposed to using transfers from other HHS discretionary programs to finance the fund.** This approach would be disruptive and harmful for other critical health care and public health programs, as we learned during the Zika outbreak. Instead, we urge the Subcommittee to create a mechanism to replenish the fund without drawing down from other programs and to work with the Appropriations Committees to ensure it receives new funding as necessary.

Second, we are concerned that the fund's stated purposes would allow it to be used in the absence of a declared or even potential public health emergency. In particular, we would not support using the fund for developing and procuring medical countermeasures in the absence of a declared or potential public health emergency. At a minimum, we recommend that the Subcommittee amend the language on page 8, lines 21-24 of the discussion draft to limit this use to a declared public health emergency or if the Secretary determines there is a significant potential for a public health threat or emergency to occur. Ideally, the AHA prefers the "uses" language included in rapid response fund section of the Senate HELP Committee's PAHPA Reauthorization bill. Section 206 of S. 2852 includes appropriate guardrails for when an emergency fund could be used. It also would permit other critical uses in a public health emergency or potential public health emergency, such as for facilitating coordination between public health and private health care entities, strengthening bio surveillance capabilities and laboratory capacity, and supporting initial emergency operations and assets for intermittent disaster response personnel.

SEC. 401. CYBERSECURITY

Last year's global WannaCry ransomware attack underscored the cybersecurity risks that hospitals and health systems continue to encounter. Given that the United States faces relentless cybersecurity threats from other nation states, it is not reasonable to expect individual health care and public health entities to be the front line of defense. Although hospitals and health systems are taking many steps to secure their systems, the AHA supports strong national cyber defenses to aid them in those efforts. **Therefore, we generally support this section's designation of ASPR as the lead agency responsible for ensuring that the health care sector is capable to provide continuity of care during cybersecurity incidents and the addition of cybersecurity responsibilities to a number of existing public health, health care and biodefense programs within ASPR.** We further agree that, as part of the National Health Security Strategy, the Secretary should promote strategic initiatives to advance countermeasures to diagnose, mitigate, prevent or treat harm from any cybersecurity threat.

However, adequately strengthening the health care and public health sector's cyber defenses will be a resource-intensive and costly endeavor, and we urge the Subcommittee to authorize additional funding to carry out these new cybersecurity responsibilities in each of the impacted programs.

SEC. 103. NATIONAL ADVISORY COMMITTEE ON CHILDREN AND DISASTERS

The AHA supports this section, which would reauthorize the National Advisory Committee on Children and Disasters (NACCD) through 2023. The NACCD, which was established to provide expert advice and consultation to the HHS Secretary on the medical and public health needs of children in disasters and public health emergencies, is an important resource for the Secretary. However, the AHA urges the Subcommittee to revise the discussion draft to clarify that federal representatives should be ex officio, non-voting members, and that the committee should incorporate additional expertise such as mental and behavioral health, children with special health care needs, and emergency medical services for children. Further, the AHA recommends that the Subcommittee reauthorize the National Preparedness and Response Science Board (previously called the National Biodefense Science Board) as well as the CDC's Children's Preparedness Unit.

We thank you for the opportunity to submit comments on the PAHPA reauthorization discussion draft and look forward to continuing to working with you on as this important legislation advances. If you have questions or would like further information, please feel free to contact me or have a member of your team contact Robyn Bash, vice president, government relations and public policy operations, at rbash@aha.org or 202-626-2672.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President