Federation of American Hospitals®

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President and CEO

March 29, 2023

The Honorable Bill Cassidy
455 Dirksen Senate Office Building
Washington DC 20510

The Honorable Mitt Romney
354 Russell Senate Office Building
Washington, DC 20510

The Honorable Bernie Sanders
332 Dirksen Senate Office Building
Washington DC 20510

The Honorable Bob Casey Jr.
393 Russell Senate Office Building
Washington, DC 20510

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

Thank you for your continued bipartisan leadership to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA). The Federation of American Hospitals (FAH) and our members appreciate the opportunity to comment on the Senate Health, Education, Labor and Pensions (HELP) Committee's Request for Information (RFI), and provide recommendations to best prepare and respond to future public health emergencies (PHEs). PAHPA is an essential component of the United States' public health security, providing critical response tools for our nation's health care infrastructure.

The FAH is the national representative of more than 1,000 tax-paying community hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The COVID-19 PHE required hospitals, in coordination with federal, state and local officials, to exercise their preparedness and response capabilities on an unprecedented scale. The health care sector can and must leverage lessons learned to ensure greater capabilities and response strategies for future emergencies, whether they be natural or manufactured disasters.

We look forward to promoting policy solutions in the reauthorization of PAHPA to ensure patients have continuous access to quality care during future emergencies, and that hospitals and frontline health care workers are best equipped to respond accordingly.

We are pleased to provide both general and specific recommendations for consideration of inclusion in the PAHPA reauthorization, based on the experiences of our member hospitals and look forward to continuing this important dialogue with the Senate HELP Committee.

Enable Automatic Waivers by Making Permanent HHS Temporary Waiver Authority

The national impact of COVID-19 necessitated the development and issuance of waivers from the federal government to give health care providers the flexibility needed to combat this pandemic. As we learn from the lessons of COVID-19, we urge you as Congressional leaders to request that HHS work with stakeholders to identify those waivers that should be activated on a "blanket" waiver basis in response to future PHEs. Doing so will help ensure that health care providers do not waste precious time, energy, and resources identifying, requesting, and waiting for the waivers to be put in place.

Hospital Preparedness Program (HPP)

The HPP has played a vital role in enhancing the ability of hospitals and health care systems to prepare for and respond to public health threats and PHEs. The HPP is currently the only source of federal funding for health care delivery system readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery.

First and foremost, we urge the Committee to ensure that the HPP is fully funded at a sufficient level as recommended by the hospital community with greater funding allocated directly to hospitals and health systems.

Specifically, the Committee asks for suggestions on ways foundational programs, such as the HPP, can be improved to ensure readiness to mount effective responses:

One such improvement would be to modernize the program to increase health care engagement and spur innovation. By statute, HPP recipients have been the same since the HPP's inception in 2002: the public health departments in all 50 states, the District of Columbia, Los Angeles County, Chicago, New York City, and all U.S. territories and freely associated states. This lack of competition has created a monopoly-like atmosphere in which HPP public health department recipients have an expectation of annual funding, regardless of performance. HPP's effectiveness could be enhanced by establishing new authorities that permit state- and jurisdiction-level competition for HPP funds. For example, state and local public health departments, academic medical centers, state and local hospital associations, and health care coalitions could all be eligible to apply to serve as the recipient for their jurisdiction. This proposal would not change the number of awards per state or jurisdiction but would create

competition within each state or jurisdiction. This reform would allow the HPP to fund those entities that are most innovative in their approach to health care readiness. It would also differentiate the largely private sector health care system from the mostly governmental public health sector, which already receives federal funding for preparedness through the CDC's Public Health Emergency Preparedness (PHEP) program.

Another improvement would be permitting HPP funding to cross state lines, and encourage health care disaster preparedness and response planning and response (e.g., health care coalitions) to reflect day-to-day care referral patterns. Patients are routinely transferred across state lines to receive higher levels of care (e.g., trauma, stroke, cardiac); however, the current HPP authorities have created state-wide programs that often do not reflect these health care operations.

Finally, a minor change to the program's name might increase the effectiveness of the program. Renaming the HPP to reflect the health care system's fundamental role in emergency response could increase effectiveness of the program as many coalitions currently believe they are planning entities, and not responders, due to the program's authorizing language.

Strategic National Stockpile (SNS) Considerations

The FAH recommends that the SNS be redesigned to align with the national supply chain. The SNS was established for procurement of medical countermeasures (MCMs) and to serve as a repository of drugs, supplies, and devices necessary to respond to a public health threat. Policymakers should ensure the SNS has appropriate resources and funding to fulfill its role as a stopgap in emergencies. However, long-term solutions also need to be considered to improve the efficiency and effectiveness of the SNS. The SNS fell short in responding to the unprecedented national demand posed by a global threat of the magnitude of COVID-19. The FAH urges Congress to conduct an evaluation that includes a root cause analysis of points of failure of the SNS under the threat of COVID-19 followed by a study focused on identifying what the proper authority, models of governance, capacity and scope of SNS need to be so as to inform a much-needed re-vamping of the SNS.

There should be an increase in health care stakeholder input into products procured by and stockpiled within the SNS. Hospitals and other health care providers are generally unaware of what products are in the stockpile, the supplies that come with requested products (e.g., whether IV tubing comes with IV anthrax antitoxin when the antitoxin is requested), the allocation strategy during a nationwide emergency, and the timeline for distribution. These are critical details which would facilitate the distribution of the SNS. Thus, increased clinician and health care operations input into the SNS would assist in more efficient stockpiling and enhance preparedness for dispensing the stockpile's products to patients and/or the public during future PHEs.

The FAH further recommends the engagement of a private sector council representing the functional components of industry that make up the operational components. The private sector council should include end-to-end leaders of the supply chain distribution enterprise, from raw

materials manufacturers to health system emergency managers, so as to inform regarding improvements that would allow the SNS to be more efficient. The private sector council should further be leveraged during the operation of the SNS to continually inform the capabilities and align the response of the SNS towards greater operational effectiveness.

The mission of the SNS has evolved over time and needs to continue to evolve from past models of static stockpiling on shelves into more nimble frameworks and data sharing partnerships. It is critical that the SNS actively engage in the nation's circulation of supplies as part of the national supply chain in line with appropriate manufacturing ramp up and streamlined distribution to where supplies are needed most. In this vein, the stocking of the SNS should also be mindful of medical supply availability in the supply chain and avoid competing with hospital acquisition of supplies needed to provide patient care. We urge increased public-private collaborations, such as the Dynamic Ventilator Reserve partnership, and increased communication among Group Purchasing Organizations (GPO), SNS, HHS, Federal Emergency Management Agency (FEMA), Food and Drug Administration (FDA), hospitals, health systems and other providers to help ensure a coordinated and comprehensive response during emergencies.

Medical Reserve Corps (MRC) and Nurse Corps

To improve the MRC, the Committee should consider granting federal (or similar) indemnification to MRC teams and regional/hospital-based disaster response teams willing to assist in other states and health care facilities experiencing emergencies.

In addition, the FAH strongly supports significant federal investments in provider loan repayment programs, including the Nurse Corps, to incentivize caregivers to serve in rural and underserved communities. Among the greatest challenges facing hospitals today is maintaining a sustainable workforce, especially in the wake of historic burnout and resignations throughout the COVID-19 PHE. We urge the Committee to prioritize measures to support frontline health care providers and maintain a robust workforce in both the short- and long-term.

Biosurveillance and Public Health Situational Awareness

The FAH supports the establishment of a Public Health Information Communication Advisory Committee to provide recommendations to the HHS Secretary on communication and dissemination of scientific and evidence-based public health information during PHEs. Misinformation was amplified throughout the COVID-19 pandemic, which put Americans at greater risk and imposed an avoidable threat to the sustainability and functionality of the health care system.

Additionally, the FAH would support the establishment of a National Health Care Data Coordination Center (Center) through a public-private partnership. All federal departments and agencies could use the Center for the collection and analysis of public health and health care data

for emerging infectious diseases and other medical surge emergencies. This would avoid the development of duplicate systems and encourage federal agency collaboration. Functions of the Center could include data integration from multiple electronic health records systems (ideally automated and in real-time) to facilitate disease forecasting and modeling, health system status reporting, and supply chain reporting.

Also, we encourage collaboration of public health agencies, such as the CDC, with health care stakeholders so the health care community can provide input ensuring CDC guidance is relevant and actionable.

Additional Support for Jurisdictional Preparedness and Response Capacity

An initiative to bolster preparedness would be to authorize an advisory committee for Health Care Strategy for Preparedness and Response as a health care-specific Federal Health Care System Advisory Committee within the Assistant Secretary for Preparedness and Response (ASPR). Current ASPR advisory committees tend to focus on medical countermeasures, therefore one dedicated specifically to health care could augment existing health care expertise within ASPR.

Finally, the establishment of a national lab for health system preparedness and response research would bolster PHE responsiveness. Like the Department of Energy's National Labs, a national lab for preparedness and response would permit HHS and other relevant Agencies to directly engage private health care experts on pilot projects—without requiring a lengthy grant-making or contractual procurement process—to determine the feasibility to scale innovations at the regional and national levels during emergencies.

Hospital Eligibility Criteria During Emergencies

All hospitals, regardless of tax-paying status, are on the frontlines in caring for patients when emergencies strike, enduring the same hardships and challenges that must be overcome to protect our health care workforce while ensuring we have the resources necessary to care for our patients. Viruses and PHEs do not distinguish between patients and the communities we serve, nor between the tax-paying status of their closest hospital. Unfortunately, in some instances, tax-paying hospitals have been excluded from participating in federal programs that play pivotal roles in enabling emergency response and expanding access to care during states of emergency. This lack of parity unjustly penalizes patients living in communities across the United States that are served by tax-paying hospitals.

Notably, the eligibility criteria used by the FEMA (as determined by the Stafford Act) excludes tax-paying hospitals from directly receiving financial assistance during declared emergencies. This exclusion leaves approximately 20 percent of hospitals nationally unable to obtain direct funding for certain covered resources that are critical for responding to PHEs and other emergencies.

Another example is that tax-paying hospitals are excluded from eligibility for certain programs that would help combat future pandemics. For example, the Federal Communications Commission (FCC) defined the eligibility criteria for its COVID-19 Telehealth Program such that tax-paying hospitals were ineligible for participation. Telehealth serves a critical role during pandemics and FAH member hospitals are often the sole provider of comprehensive medical care in their communities, especially in rural America.

For these reasons, all hospitals, regardless of tax-paying status, should be eligible for the same necessary assistance as public or private non-profit hospitals during declared emergencies.

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The FAH and its members thank you for your leadership throughout the COVID-19 PHE, and in proactively preparing for future PHEs by spearheading the PAHPA reauthorization. We look forward to continuing to work with you and the Senate HELP Committee to best prepare the nation's health care infrastructure for future emergencies. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,