TESTIMONY

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"Examining the National Response to the Worsening Coronavirus Pandemic"

Submitted
By
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Good morning, Chairman Thompson, Ranking Member Rogers, and distinguished Members of the Committee. My name is Pete Gaynor, and I am the Administrator of the Federal Emergency Management Agency (FEMA). Thank you for the opportunity to discuss FEMA's response and the actions currently underway to protect the American people during the coronavirus (COVID-19) pandemic, as well as the Agency's ongoing engagement with the emergency management community to enhance disaster preparedness within a COVID-19 environment.

On behalf of the men and women of FEMA, I would like to begin by offering my condolences to the loved ones of the 140,000 Americans who have lost their lives to COVID-19. One life lost is one life too many, and our hearts go out to all those who have been affected by the pandemic.

For the first time in the United States' history, there are 114 concurrent Major Disaster Declarations—at least one in every single state, 5 territories, the Seminole Tribe of Florida, and the District of Columbia. From islands across two oceans to the cities and farms of America's heartland, the scale of this historic event has required FEMA to adapt its response practices and workforce posture in order to both respond to COVID-19 and simultaneously maintain mission readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires.

Regardless of the challenges that FEMA continues to confront, the bedrock of our mission remains constant: helping people before, during, and after disasters. The Nation is counting on us to accomplish our mission, and we will do so in accordance with our core values of compassion, fairness, integrity, and respect.

Since March 13th, FEMA has obligated over $8.3 billion from the Disaster Relief Fund to support State, Local, Tribal, and Territorial (SLTT) partners in their COVID-19 response-related activities, with the first $1 billion obligated in 11 days. $1.67 billion has been allocated in support of the National Guard and Title 32 troops, as well as the deployment of 5,300 DOD Title 10 medical professionals who have provided critical medical support to numerous hospitals under stress. To further bolster the medical infrastructure of SLTT partners, we have constructed 38 Alternate Care Facilities and deployed 41 Federal medical stations through mission assignments to the U.S. Army Corps of Engineers.

As part of the Whole-of-America response, as of July 10, FEMA, HHS, and the private sector combined have coordinated the delivery of approximately 181.8 million N-95 respirators, 746.5 million surgical masks, 30.6 million face shields, 329.1 million surgical gowns, and over 19.1 billion gloves.

FEMA's unprecedented support for SLTT partners extends well beyond financial support or the distribution of personal protective equipment (PPE). FEMA's response has served to stabilize lives in the most fundamental ways, as demonstrated by the distribution of $27 million in commodities through services such as emergency food shipments, and $56.5million in support for Crisis Counseling across 53 states and territories providing free, confidential counseling through community-based outreach and educational services.

I would like to thank the Members of this Committee for authorizing many of the resources FEMA and SLTT partners need to meet these complex and historic mission requirements, as well as prepare for future disaster considerations. Today's testimony will offer an overview of FEMA response efforts and strategies for COVID-19, some of the lessons we have learned, and

implementable planning considerations as we pivot to prepare for future disasters during a pandemic response.

Overview of FEMA Response

On March 13th, 2020, President Trump declared a nationwide emergency pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). As part of this unprecedented nationwide declaration, all SLTT partners became immediately eligible for FEMA Public Assistance (PA) Category B, emergency protective measures as authorized by section 403 of the Stafford Act and funded by the Disaster Relief Fund. Such assistance includes, but is not limited to, funding for Alternate Care Facilities, tribal medical centers, non-congregate sheltering, community-based testing sites, disaster medical assistant teams, mobile hospitals, emergency medical care, and the transportation and distribution of necessary supplies such as food, medicine, and personal protective equipment.

Subsequent to the President's nationwide emergency declaration, all states, territories, and some federally recognized tribes requested Major Disaster Declarations. To date, all 50 states, five territories, the District of Columbia, and the Seminole Tribe of Florida have been approved for Major Disaster Declarations to assist with additional needs. FEMA is also working directly with 85 tribal governments under either the nationwide emergency declaration or a Major Disaster Declaration.

In keeping with the Stafford Act, FEMA allocates funding to cover 75 percent of costs of Public Assistance, and SLTT governments are responsible for the remaining 25 percent. To help SLTT governments nimbly respond to and recover from COVID-19, the Department of Treasury recently announced that Coronavirus Relief Fund dollars, provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, may be used to pay for FEMA's cost share requirements under the Stafford Act.

On March 19th, FEMA's role in the pandemic response changed. Under the direction of the White House Coronavirus Task Force, FEMA moved from playing a supporting role in assisting the U.S Department of Health and Human Services (HHS), which was designated as the initial lead federal agency for the COVID-19 pandemic response, to coordinating the Whole-of-Government response to the COVID-19 pandemic.

Upon transitioning into this management role, FEMA merged interagency priorities to help guide the everyday operations of the federal government's response. In keeping with the leadership of the White House Coronavirus Task Force, the top priority was to protect the health and safety of the American people by executing an unprecedented Whole-of-Government and Whole-of-America effort. To best accomplish this objective and combat the public health crisis confronting the country, FEMA continued to coordinate response practices in alignment with the medical priorities previously established by HHS's Assistant Secretary for Preparedness and Response - shield the vulnerable, shelter the susceptible, save the sick, and sustain supplies.

FEMA further infused its own operational priorities into the Whole-of-Government response by emphasizing the need to preserve the workforce and take proactive measures to protect response employees, continuously conduct mission essential emergency management functions within a COVID-19 degraded environment, and lead federal operations on behalf of the White House Coronavirus Task Force.

In Washington, D.C., the National Response Coordination Center (NRCC) transformed into the fulcrum of federal interagency coordination efforts under the Unified Coordination Group (UCG), which is co-chaired by me within my capacity as the FEMA Administrator, and Robert Kadlec, M.D., HHS's Assistant Secretary for Preparedness and Response. Eight Task Forces were quickly assembled to address top priorities for the pandemic response in coordination with the NRCC and focused upon mission critical functions such as: gaining and maintaining situational awareness of medical equipment supply and demand, including laboratory testing supplies and protective equipment required for health care professionals or critical infrastructure workers; establishing a decision matrix for the allocation of finite resources within the context of shifting hotspots; ensuring effective cross-communication and coordination with SLTT partners to increase their response capacities; maintaining positive response momentum by protecting and rotating staff for rest periods; increasing the size of the workforce; and keeping mission essential employees constantly but safely engaged.

In addition, FEMA's ten Regional Offices have served on the front lines of the response, to include the activation of their respective Regional Response Coordination Centers (RRCC). In support of this Whole-of-Government effort, there have been personnel from agencies such as the DoD, HHS, Centers for Disease Control and Prevention (CDC), Department of Veterans Affairs (VA), U.S. Army Corps of Engineers (USACE), Defense Logistics Agency (DLA), Cybersecurity and Infrastructure Security Agency (CISA), and Customs and Border Protection (CBP) imbedded within the NRCC and RRCCs to coordinate response and recovery efforts both nationally and at the local level.

At its peak, over 50,094 federal personnel were deployed in this coordinated process to bring the full resources of the Federal government to bear. This includes 3,200 FEMA employees and 4,200 U.S. Public Health Service Commissioned Corps officers from HHS deployed in support of the response, as well as the 42,000 National Guard members responsible for conducting testing and PPE distribution, among other COVID-19 response support missions nationwide. Additionally, there were the 13,680 Title 10 forces, including 5,300 medical personnel, working to support the response to the public health emergency. To further bolster SLTT medical infrastructure, 17,636 US Army Corps of Engineers personnel assisted with the construction of Alternate Care Facilities.

Building Surge Capacity

One of the first priorities for FEMA, HHS, and the UCG was to increase the surge capacity of SLTT hospitals. In order to accomplish this objective and protect the safety of patients, health care providers, and the American public, FEMA directed the USACE to work closely with SLTT officials to construct Alternate Care Facilities (ACF). An ACF is a building such as a dormitory or civic convention center that is temporarily converted into a medical treatment facility during a public health emergency to provide additional space if traditional health care institutions are filled beyond capacity. These locations were identified and constructed through close partnerships between USACE and SLTT officials, with local COVID-19 considerations and future projections in mind. Upon construction, the ACF is then state or locally managed, and eligible for FEMA Public Assistance Category B funding under the Stafford Act for both their construction and continued operations. In total, we have constructed 38 Alternate Care Facilities.

Another type of ACF utilized by FEMA and our federal partners during the COVID-19 response are Federal Medical Stations (FMS). An FMS is a pre-packaged ACF, and it is composed of federal equipment and supplies that are deployed and operated by the federal government using supplies from the Strategic National Stockpile (SNS). In total, 41 FMSs were deployed through mission assignments to the USACE. However, due to the scale of the COVID-19 pandemic and significant demands for finite supplies within the SNS, FMSs served to augment SLTT medical infrastructure in critical areas of urgent need and could not be deployed to meet every community's requests.

Managing Worldwide Critical Shortages

From the outset, a key element of FEMA's response has been managing shortages of medical supplies needed to combat the pandemic, such as PPE, ventilators, swabs, and the chemical reagents required for testing. This effort alone has presented an historic challenge for FEMA and its federal partners. COVID-19 has been a global crisis—leaders across over 150 countries have simultaneously been competing for the same medical supplies. We have been further challenged as most of the manufacturing for PPE occurs in Asia, where the virus significantly slowed down private sector production capabilities.

Concurrently, American medical professionals on the front lines of the pandemic have required an exponentially increased volume of PPE and other medical supplies. On average, the United States began consuming a year's worth of PPE in a matter of weeks. FEMA worked closely with HHS to ensure that locations in danger of running out of supplies within 72 hours received life-saving equipment from the Federal government's reserve within the Strategic National Stockpile (SNS), as administered by HHS.

Phase 1: Distributions from HHS' Strategic National Stockpile

From the beginning, FEMA and HHS understood and acknowledged that the SNS alone could not fulfill all of our Nation's requirements. The SNS was never designed or intended to fully supply every state, territory, tribe and locality in the United States concurrently and cannot be relied upon as the single solution for pandemic preparedness. It was principally designed as a short-term stopgap buffer to supplement state and local supplies during a public health or national security emergency.

During the SNS distribution process, the Federal government worked to balance each state's requests with the need to prioritize hotspots and locations in danger of depleting their own lifesaving medical supplies within 72 hours. Emergency supply shortage notifications were relayed from the local level to state emergency managers or public health departments, who then passed them on to the Regional Response Coordination Centers to be vetted by FEMA, HHS, and CDC. These requests were then prioritized and shared with the National Response Coordination Center (NRCC) to adjudicate. The NRCC had the benefit of a national perspective to inform the decision-making process. This national perspective incorporated understandings of increasing or decreasing disease activity and its effects, a broad picture of where resources were needed most urgently, and the resources available in the SNS.

Given the finite number of medical devices such as ventilators in the SNS and the limited capacity of the private sector supply chains to meet the demand, the Federal government adopted

a process to manage federal ventilator resources to ship them to the states only in the quantities needed to manage the immediate crisis. As such, ventilators were designated as strategic national assets to be distributed in accordance with immediate need. Ventilator donations from the private sector and federal partners such as the DoD made meaningful contributions to SNS distributions, and although there was an extremely finite supply of ventilators available, we were able to fulfill every state's validated request. Due to these Whole-of-America efforts, improved treatment techniques in hospitals, and federally supported innovations within the American healthcare community to modify or retool medical devices such as anesthesia machines, we are proud to say that no one who needed a ventilator went without a ventilator.

Decisions on where to allocate these limited medical resources were thoughtfully and deliberately informed by a series of intervening variables and a data-driven approach. Considerations such as the number of cases, deaths, available Intensive Care Unit (ICU) beds, available ventilators, prevalence of vulnerable populations, and knowledge of a location's medical infrastructure helped to inform FEMA and HHS decision making. A series of influenza models, such as the University of Washington's Institute for Health and Metrics (IHME) Model funded by the Gates Foundation specifically for COVID-19, also played a critical role in helping FEMA allocate medical resources.

Phase 2: The Supply Chain Stabilization Task Force and Project Airbridge

To address the imbalance between supply and demand for PPE and other medical supplies, the Supply Chain Stabilization Task Force, under the direction of Rear Admiral John Polowczyk, was swiftly assembled on March 20th to address widespread shortfalls amidst the global competition for life-saving equipment. The Task Force consisted of a multi-faceted team across the US government, and liaisons from the private sector. In support of this Whole-of-Government effort, there have been over a dozen agencies and departments—such as the DoD (including the Defense Logistics Agency (DLA)), HHS, (including the CDC), the Department of Homeland Security, and the Department of Veterans Affairs (VA)—embedded within the Supply Chain Task Force to coordinate response efforts.

The Task Force, in conjunction with other agencies and Task Forces, sourced PPE, swabs, ventilators and other critical resources for points of care nationwide, with a special consideration given to supporting healthcare workers on the front line and then other priority groups including first responders and critical infrastructure workers in lifeline industries who are unable to practice social distancing due to the nature of their work.

To maintain the country's existing medical supply chain infrastructure efficiently, the Task Force, along with FEMA and HHS, has sought to supplement – not supplant – the overall supply chain through a variety of strategies. Efforts to date have focused on reducing the medical supply chain capacity gap to both satisfy and relieve demand pressure on medical supply capacity. To execute a strategy maximizing the availability of critical protective and lifesaving resources, the Task Force applied a four-pronged approach of Preservation, Acceleration, Expansion and Allocation to rapidly increase supply today and expand domestic production of critical resources to increase long-term supply capabilities.

Through these lines of effort, the Task Force worked with the major commercial distributors to facilitate the rapid distribution of critical resources in short supply to locations where they were needed most. This partnership enables a Whole-of-America approach to combat the pandemic.

A key example of this public-private partnership in action is Project Air Bridge. Established in less than 10 days, Project Air Bridge expedited the movement of critical supplies from the global market to medical distributors in various locations across the U.S. FEMA covered the cost to fly the supplies, enabling the delivery of PPE into the U.S. from overseas factories. To be clear, the Federal Government does not own the content of these flights, but simply facilitated the rapid transportation of these materials to the United States on behalf of the six largest American medical distributors who have partnered with the Supply Chain Task Force.

Remarkably, this airbridge cut the duration of transporting international shipments down from *37 days* on a ship to just *one day* by air. Under the leadership of the White House Coronavirus Task Force, FEMA and its partners successfully innovated to deliver PPE to America 36 times faster. Put another way, the Airbridge ensured that PPE was delivered to the United States in *less than 3 percent* the amount of time it traditionally takes to transport PPE.

After the cargo was flown in via the air bridge, 50 percent of the supplies on each plane were sent by the distributors to points of care in areas of greatest need. These areas were determined by HHS and FEMA personnel within the National Resource Prioritization Cell (NRPC), based on information provided by states and CDC epidemiological data. In addition, distribution decisions have been informed by the immense amounts of data provided by the six distributors who partnered with Project Air Bridge. These companies are Cardinal Health, Concordance, Owens and Minor, McKesson, Medline, and Henry Schein.

These six distributors allowed us to see what inventory is coming in and where it is going – down to the zip code. This data has provided the Task Force the ability to prioritize hospitals, nursing homes and other healthcare facilities with the most critical needs and highest COVID-19 rates. This information was updated frequently by the NRPC to provide an accurate view of evolving conditions, PPE accessibility, and shifting hotspots.

The remaining PPE from Project Air Bridge was distributed through the companies' regular networks into the broader U.S. supply chain. Prioritization was given to hospitals, health care facilities, and nursing homes around the country. In some cases, the Federal Government may have purchased some of the supplies upon arrival to provide to states with identified and unmet needs. This is truly an historic accomplishment by FEMA and its federal partners. The result was a data-informed process that helped FEMA better ensure the right supplies got to the right places at the right time to save lives.

Project Airbridge was integral to the federal strategy to manage critical shortages of PPE and other medical supplies by accelerating international deliveries until domestic and foreign manufacturers could increase production to well above pre-COVID-19 levels and standard supply chains could begin to stabilize. From March 29th to June 30th, Project Air Bridge completed 249 flights and expedited the delivery of nearly 4.5 million N95 respirators, almost 1 billion gloves, approximately 122 million surgical masks, and more than 60 million surgical gowns, among many other critical medical supplies. As of July 1st, Project Airbridge has ceased all activities, but retains the ability to be reactivated in accordance with shifting conditions.

Phase 3: Transition to Expedited Shipping and Increased Manufacturing

Although Project Air Bridge was able to fill critical shortages of PPE and other medical supplies, it was never intended to be a permanent component of a stabilized supply chain. As global production levels continue to increase, we have transitioned towards traditional and expedited

sea lane shipping with cargo ships able to carry considerable volume. On May 10th, FEMA's first shipment of N-95 respirators arrived by sealift in the Port of Long Beach, California, with a subsequent delivery of N-95s arriving on May 21st. Subsequently, we have scheduled additional sealift delivery through the month of July. This will provide an additional 62.7 million N-95 respirators, 1.3 million gloves, and 6.2 million gowns into the U.S. This is approximately 390 cargo containers of material.

As part of the Whole-of-America response, as of July 14, FEMA, HHS, and the private sector combined have coordinated the delivery of approximately 181.8 million N-95 respirators, 746.5 million surgical masks, 30.6 million face shields, 329.1 million surgical gowns, and over 19.1 billion gloves.

Expansion of the industry has also been simultaneously taking place. Manufacturers are enhancing domestic production capacity with additional machinery, and in some cases re-tooling assembly lines to produce new products. As an example of this work, the Food and Drug Administration (FDA) is providing assistance to manufacturers who have produced other products, such as automobiles, on adding production lines or alternative sites for making more ventilators during the COVID-19 public health emergency.

In addition, the Supply Chain Stabilization Task Force is working through over 350 leads to match American businesses who have excess raw materials, workforce, or factory production capacities combined with an overwhelming desire to provide their support to the national response effort. Task Force members are actively working to facilitate the creation of private sector partnerships to pair companies that have offered their excess factory production capacity, the talents of their workforce and access to their raw material supply chains with critical supply manufacturers who have expertise in producing PPE, ventilators, and other needed equipment.

As part of the federal efforts to scour the globe for PPE and consider all opportunities, FEMA and its federal partners explored thousands of leads both overseas and across our country. Whether a lead came from the White House Coronavirus Task Force, Members of Congress representing businesses in their State, or through an enterprise's unaffiliated inquiry, we processed all leads through standard vetting procedures and the federal procurement process. To be clear, FEMA follows the law and all applicable procedures prescribed in the Federal Acquisition Regulation and other agency procedures when entering into contracts. To further support this effort, a firewall was established between those responsible for identifying leads and those responsible for the procurement of contracts. In response to the COVID-19 pandemic, FEMA has awarded a total of 676 contract actions for a total value of $1.60 billion to date on behalf of HHS and other federal partners in support of SLTT partners.

To help FEMA pivot towards hurricane season preparations, on April 28th, FEMA's role within the federal response to the COVID-19 pandemic began to evolve. The White House Task Force, DOD, HHS, and the Supply Chain Task Force (SCTF) agreed that the DOD would assume responsibility for procuring emergent PPE items in response to COVID-19 on behalf of FEMA and HHS. The official transition concluded May 29, 2020. Moving forward, new procurements for COVID-19 will largely reside with the DOD's Defense Logistics Agency, which has a robust procurement and distribution capacity and capability.

This transition will help FEMA to better prepare and support the upcoming hurricane season and other potential disasters Americans may face. As FEMA and its partners begin returning to

Steady State operations, the eight Task Forces within the NRCC have begun transitioning into Working Groups. All personnel previously assigned to the eight Task Forces have either been demobilized or realigned under six corresponding working groups. Regardless of FEMA's role in the management and distribution of critical resources, this COVID-19 response effort will continue to be federally supported, state managed, locally executed, and in this instance, private sector enabled.

Like all task forces assembled to confront specific challenges in crisis, the Supply Chain Stabilization Task Force's lines of effort require longer-term institutional solutions to ensure that America is ready for a sustained response to COVID-19 and other pandemics. The expansion of our domestic industry to increase the production of PPE and other supplies is key to our ability to conduct a sustained response. One of the most prominent examples of efforts to expand the domestic industry is demonstrated by interagency efforts to leverage the Defense Production Act.

The Defense Production Act

The Defense Production Act (DPA) of 1950, as amended (50 U.S.C. §§ 4501 et seq.) is an authority the President may use to expand the production of supplies and services from the private sector needed to promote the "national defense," a term that includes emergency preparedness and response activities conducted pursuant to Title VI of the Stafford Act and protection and restoration of critical infrastructure operations. The authority to use the DPA for health and medical resources for COVID-19 was delegated to the Department of Homeland Security (DHS) and HHS in Executive Order 13911, "Delegating Additional Authority under the Defense Production Act with Respect to Health and Medical Resources to Respond to the Spread of COVID-19." The Secretary of Homeland Security delegated its authority to me, as the FEMA Administrator. FEMA specifically has relied on the DPA, as delegated and in coordination with our federal partners, to focus on increasing the production and distribution of ventilators, N-95 masks, and medical countermeasures.

Beginning on March 19th, the Unified Coordination Group (UCG), which I chair, and which includes leaders from FEMA, the Department of Health and Human Services, the Department of Defense (DOD), and other federal agencies, reviewed all requests for use of the DPA for COVID-19 and elevated them to the White House Coronavirus Taskforce for decision.

In response to the COVID-19 pandemic, DPA authorities can be used to address disruptions in medical and healthcare lifelines necessary for the continuous operation of critical government and business functions which are essential to human health and economic security. The DPA enables the Federal Government to leverage domestic industry's ability to supply materials and services in support of the national defense. In addition to using the DPA to protect essential health resources and combat materials shortages, the Federal Government is also using the DPA to increase domestic manufacturing capabilities, which will help to ensure the United States' future preparedness for pandemics is not overly reliant upon the foreign production of medical supplies which, as we have seen, may be vulnerable to supply chain disruptions.

For response to the COVID-19 pandemic, FEMA's authorities under the DPA are described in Titles I, III, and VII of the Defense Production Act.

DPA Title I - Priorities and Allocations:

Title I of the DPA provides the Federal government with the authority to require contracts and orders to be accepted and to receive priority over non-rated contracts and orders not prioritized by the Federal Government for the national defense. Priority Rated contracts and orders take precedence over *all* unrated contracts and orders, when necessary to meet delivery dates specified in the rated orders. Priority ratings can be added to contracts and orders to procure health resources, including PPE, to ensure the federal government has the necessary resources to combat COVID-19.

In response to a Presidential Memorandum, "Memorandum on Order Under the Defense Production Act Regarding 3M Company," on April 3, 2020 FEMA issued a DPA order to 3M for 166.5 million respirator masks from its factories in China, South Korea and Singapore, to be delivered from April to July 2020. FEMA is using this rated order to fill state requests for support and to help fill normal supply chains for PPE.

DPA Title I also authorizes FEMA to allocate limited supplies of materials, services, and facilities in the domestic market, which allows the Federal government to control the distribution of scarce, high-demand health resources. FEMA has also exercised its delegated allocation authority under Title I to impose export limitations ensuring that critical medical supplies needed for the domestic response to COVID-19 are preserved for domestic use. In furtherance of President Trump's April 3rd "Memorandum on Allocating Certain Scarce or Threatened Health and Medical Resources to Domestic Use," FEMA published a Temporary Final Rule to allocate five categories of scarce medical items. These categories include N-95 respirators, surgical gloves, PPE surgical masks, and other air purifying respirators for domestic use. FEMA reviews planned exports of these items and may purchase them, return them for distribution in the domestic market, or, if they fall within one of several established exemptions, allow them to proceed to export. FEMA coordinates closely with our federal partners in implementing this order, including DHS's CBP, the U.S. Department of Commerce, HHS's FDA, and the U.S. Department of State.

DPA Title VII – Voluntary Agreements with Private Sector Partners:
Based on a finding that COVID-19 presents a direct threat to the national defense and its preparedness programs, FEMA has also initiated efforts under Title VII of the DPA to establish a Section 708 voluntary agreement for the response to COVID-19 and future pandemics. Under Title VII, FEMA plans to enter into a voluntary agreement with private sector manufacturers and distributors of critical healthcare resources necessary in a pandemic. Participants in a voluntary agreement are granted relief from antitrust laws for actions taken pursuant to a voluntary agreement at the direction of the federal government.

As part of the effort to develop a voluntary agreement, FEMA held an open meeting on May 21st to present the draft agreement and solicit stakeholder feedback. Consistent with positive feedback and interest expressed by industry partners, FEMA is in the process of finalizing the agreement. If this agreement is approved by the Attorney General and the Federal Trade Commission, this agreement would formalize the unity of effort between the private sector and the federal government for integrated coordination, planning, and information sharing for the manufacture and distribution of PPE, pharmaceuticals, and critical healthcare resources identified as necessary to respond to COVID-19 and future pandemics.

DPA Title III – Expansion of Productive Capacity and Supply
Title III of the DPA allows the Federal government to make loans, loan guarantees, and to take other actions to facilitate increased production capabilities needed to maintain, expand, or protect services and materials essential to the national defense. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) allocated $1 billion for Title III projects related to COVID-19. Title III funds are held in the DPA Fund, managed by the DOD. These funds have been allocated to support increased production capacity and speed of production by DOD and HHS for critical healthcare resources including N-95 respirators, test kits, vaccines, and other pharmaceuticals.

Lessons Learned

FEMA has responded to this pandemic while continuing to adapt its operations and procedures to support preparation for complex future crises. Among the first lessons learned was the need to preserve PPE and prioritize its distribution

Prioritization and Preservation
Within the context of a disrupted supply chain, it quickly became apparent that healthcare workers, first responders, patients, and critical infrastructure workers needed prioritization for distributed PPE. While increased production capacity was coming online, FEMA, CDC, and other partners ensured that scarce PPE was allocated to those on the frontlines of the pandemic, and also maximized the utility and useful life of available PPE by releasing guidance to reduce, reuse, and repurpose this PPE. Due to global PPE shortages, the implementation of contingency and crisis capacity plans were sometimes necessary to ensure the continued availability of protective gear.

The BATTELLE Critical Care Decontamination System (CCDS) became another component of the plan to preserve PPE. These units can decontaminate compatible N95 respirators using a mobile CONEX box-based Vapor Phase Hydrogen Peroxide (VPHP) generator. It is the subject of an emergency use authorization issued by FDA, with capacity to decontaminate 80,000 such respirators daily. The Federal Government purchased sixty systems and distributed 45 for use nationwide, and FEMA continues to support their distribution.

Next-Generation SNS
Moving forward, we must have a ready and responsive SNS, which is why FEMA, HHS, and DoD are continuing to work together on the President's vision for a Next-Generation SNS. A transformation is required for a holistic supply chain ecosystem responsive to the unique needs of each region of the U.S. This includes developing supply chain intelligence, strengthening local, state, and Federal partnerships, and expanding domestic manufacturing for a successful future. This strategic commitment to modernize the SNS is necessary for a stronger nation prepared to meet any local, regional, or national event. Thanks to U.S. production, we now have 49,849 ventilators in the Strategic National Stockpile as of July 16th, which is more than we did before the pandemic. Similarly, before the COVID-19 pandemic, the SNS had fewer than 18 million N95 masks, and we are now growing the reserve through the DPA to include 300 million. Furthermore, whereas the SNS previously did not contain ventilator pharmaceuticals, it will now have a three months' supply in stock.

Rapid Testing for Vulnerable Populations

Given the wide selection of platforms to administer COVID-19 diagnostic testing and the supply chain limitations for the materials needed to support them, FEMA supported HHS efforts to prioritize rapid testing for vulnerable populations such as those found in nursing homes. Prioritizing the limited number of rapid tests for populations with underlying health considerations was key to facilitating a rapid response and the strategic distribution of scarce supplies. COVID-19 diagnostic platforms with longer turnaround times were found to be more appropriate in situations with lower risk of rapid spread and escalation. In further support of vulnerable populations within nursing homes, FEMA has coordinated 26,222 deliveries totaling a 14-day supply of personal protective equipment to all 15,400 Medicaid and Medicare-certified nursing homes.

Rapid testing was also proven to be an effective tool in places such as the Navajo Nation, in which limited medical infrastructure and high rates of chronic illnesses combined to create an at-risk demographic. Rapid testing, as supported by HHS, Indian Health Services, and FEMA, has allowed for increased diagnostic screenings above the national average.

As part of our Agency's efforts to support HHS led community-based testing strategies, FEMA continues to support the White House Coronavirus Task Force and the Administration's Testing Blueprint. Beginning in early May, large quantities of testing swabs and transport media began shipping to help increase testing capacity in support of individualized state, territorial, and tribal plans. As of July 10, FEMA has procured and delivered over 36.9 million swabs and 28 million tubes of transport media. Each state, territory, and tribe will develop its own distribution strategy to align with its testing plan and unique needs. Nationally, partnerships with major retail companies and local independent pharmacies to increase testing access will provide Americans with faster, less invasive, and more convenient testing for under-tested and socially vulnerable communities.

Rumor Control and Myth Busting

Throughout all stages of FEMA's COVID-19 response, we have consistently worked to correct misconceptions about the Agency or Federal government's actions and established a Rumor Control Page on our website to assist in this effort. The Agency frequently gets questions regarding FEMA "seizing" or "commandeering" critical PPE. To be clear, FEMA does <u>not</u> seize PPE from its federal, state, local, tribal, or territorial partners, hospitals, or any entity engaged in lawful transactions to distribute these resources. FEMA does not divert any PPE orders to replenish the Strategic National Stockpile.

However, it is true that certain individuals and businesses are trying to profit from the confusion and fear surrounding COVID-19, hoarding scarce resources with intent to resell them at prices in excess of prevailing market prices. This price gouging profoundly harms the Nation's ability to fight the COVID-19 pandemic and protect those men and women on the medical front lines of that fight. The U.S. Department of Justice (DOJ), under the direction of Attorney General William Barr, established the COVID-19 Hoarding and Price Gouging Task Force, focused on the detection, investigation, and prosecution of illegal hoarding and price gouging related to the pandemic. In some instances, FEMA has assisted the DOJ in its anti-price gouging efforts by issuing rated orders requested by the Hoarding and Price Gouging Task Force to purchase hoarded stockpiles that DOJ has identified as being involved in price gouging efforts.

In addition to concerns about price gouging, FEMA is aware of the threat posed by fraudulent PPE being manufactured, acquired, and shipped to customers desperate to obtain PPE for use in healthcare and other industries. The U.S. Government, academia, and the private sector are working collaboratively to minimize the risk to Americans posed by fraudulent PPE.

Firefighter Grant Modernization Efforts

To better support SLTT partners and first responders within the context of the COVID-19 pandemic, FEMA has adapted its Assistance to Firefighter Grant (AFG) and Staffing for Adequate Fire and Emergency Response (SAFER) Grants programs. For example, FEMA's grant modernization efforts have evolved to allow for virtual consultations with the fire services on program development and virtual peer reviews. These new capabilities have reduced risk for participating parties and accelerated the reviewal process, with competitive AFG-Streamlined applications able to be completed in under 1 month instead of the typical average of 6 months for the traditional AFG Program.

Furthermore, Acting Secretary Wolf of DHS exercised his discretionary authority to relax certain requirements within the SAFER Grant Program. By waiving salary caps, cost shares, and prohibitions on supplanting previously budgeted funds, we have reduced financial burdens on applicants and expanded the number of fire departments able to apply. With many municipalities facing a reduction in tax revenue, the waivers for the FY 2020 SAFER Grant Program will allow fire departments to retain or rehire firefighters facing layoffs. DHS and FEMA will provide these fire departments with 100 percent of the funding needed to hire firefighters over the next three years. FEMA anticipates opening the FY20 application later this calendar year.

Disaster Preparedness in a COVID-19 Environment

COVID-19 is not the first nor the last pandemic the American people will face. It is, therefore, imperative that we continue to prepare at all levels of government, within our communities, and across the private sector by learning from our experience with this novel coronavirus. Furthermore, building a culture of preparedness through a Whole-of-America response could become an important component of our ability to most effectively respond to other disasters such as hurricanes or wildfires during a sustained pandemic response.

Operating in overlapping disaster environments will create new intricacies within already complex mission requirements. For example, there will be a new need to evacuate strategic national assets such as ventilators or key pharmaceuticals. Evacuating people within the current COVID-19 environment will present an even larger challenge, and it will likely require the widespread availability of non-congregate sheltering. Furthermore, COVID-19 may slow down state, territorial, and tribal abilities to conduct damage assessments for disasters such as flooding, severe storms, and hurricanes. Response to other disasters, in turn, can slow down the ability of officials to collect crucial information about COVID-19 cases and stymie their ability to share the critical data needed to combat it. Consequently, there is a potential for a compounded effect that could result in a larger emergency than each disaster would be on its own. These are just some of the considerations FEMA has accounted for as we pivot to prepare for what could become active hurricane and wildfire seasons.

2020 Hurricane Season Operational Guidance

With a watchful eye on hazards of any type, on May 20th, FEMA released COVID-19 Pandemic Operational Guidance for the 2020 Hurricane Season to help emergency managers and public health officials best prepare for disasters, while continuing to respond to and recover from COVID-19. The guide describes anticipated challenges to disaster operations posed by COVID-19, as well as actions emergency managers and public officials can take to prepare for those challenges. By creating a shared understanding of expectations among FEMA and our SLTT partners, the nation will be better positioned to achieve successful operational outcomes in disaster response and recovery efforts. While this document focuses on hurricane season preparedness, most planning considerations can also be applied to any disaster operation in the COVID-19 environment, including no-notice incidents, flooding and wildfires, and typhoon response.

FEMA expects to maintain COVID-19 activation into the 2020 hurricane season in order to best support SLTT operations. To ensure that operational decisions are made at the lowest level possible, consistent with the National Response Framework, FEMA is organizing to prioritize resources and adjudicate accordingly, if needed.

FEMA personnel who are currently deployed will be prepared to pivot to support emergent needs. FEMA regions continue to provide technical assistance and coordination for a range of program areas with their respective SLTT partners. FEMA is also well-positioned with thousands of personnel in the field supporting existing operations, thousands more available ready to support emergent disaster operations, and more personnel joining the Agency through virtual onboarding every two weeks. In order to better adapt plans in this environment and support our partners, FEMA programs will continue to provide assistance to survivors, but many programs may require online or phone registration processes (in lieu of in-person), remote assessments or inspections, and adapted program delivery within impacted areas experiencing localized outbreaks or periods of peak COVID-19 activity. However, if and when SLTT partners are overwhelmed, FEMA is prepared and postured to provide program support, regardless of delivery method.

At such a pivotal time for this country, the FEMA workforce has risen to these unprecedented circumstances and met our mission each and every day. We are adaptable, resilient, and support each other. To help protect our workforce, FEMA released to a roadmap for the Agency in June concerning the opening FEMA facilities in the future. All FEMA facilities will be required to have safety protocols established prior to welcoming any employees back into a physical facility. This phased approach will ultimately result in a much smaller permanent footprint in our facilities than we had prior to the pandemic, without sacrificing services. As an example of our Agency's continuing services in a protective workforce posture, FEMA's Congressional and Intergovernmental Affairs Division has completed over 600 engagements with congressional and SLTT officials since shifting to widespread telework practices.

Conclusion

In closing, I would like to emphasize my pride and gratitude to the men and women of FEMA, as well as my gratitude to our partner departments and agencies for their adaptability, hard work, and endurance during this unprecedented response. Many have risked their health during the COVID-19 response, and their safety and wellbeing remain at the very top of our Agency's priorities.

Furthermore, this Agency would like to thank all Americans. Through coordinated social distancing campaigns across the country, the sacrifices made by millions of Americans bought valuable time as part of this Whole-of-America response. These contributions by the public allowed FEMA and its partners to strategically allocate, and then continuously shift, globally scarce resources such as ventilators to hotspots where they could immediately save lives within a 72-hour window. This Whole-of-America response was personified by leaders in places such as Washington State who voluntarily donated their ventilators to new hotspots in locations like New York.

Finally, I again express my appreciation to Congress and the President for providing FEMA with the necessary resources to meet very complex mission requirements and conditions. This unprecedented response will continue to require a Whole-of-America effort, and FEMA looks forward to closely coordinating with Congress as we work, together, to protect the health and safety of the American people during the COVID-19 pandemic. Thank you for this opportunity to testify. I look forward to answering any questions that you may have.