CONFRONTING THE CORONAVIRUS: PERSPECTIVES ON THE COVID–19 PANDEMIC ONE YEAR LATER

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

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CONFRONTING THE CORONAVIRUS: PERSPECTIVES ON THE COVID–19 PANDEMIC ONE YEAR LATER

Wednesday, February 24, 2021

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 a.m., via Webex. Hon. Bennie G. Thompson [Chairman of the committee] presiding.

Present: Representatives Thompson, Jackson Lee, Langevin, Payne, Correa, Slotkin, Cleaver, Green, Clarke, Swalwell, Titus, Watson Coleman, Demings, Barragán, Gottheimer, Torres, Katko, Higgins, Guest, Bishop, Van Drew, Norman, Miller-Meeks, Harshbarger, Clyde, Gimenez, LaTurner, Meijer, Cammack, Pfluger, and Garbarino.

Chairman THOMPSON. Good morning. Our Ranking Member will be joining us shortly.

The Committee on Homeland Security will come to order. The committee is meeting today to receive testimony on confronting coronavirus perspectives on the COVID–19 pandemic 1 year later.

Without objection the Chair has authorized to declare the committee in recess at any point.

This gentlelady from Florida, Ms. Demings, shall assume the duty of the Chair in the event that I run into technical difficulties.

With that, I recognize myself for an opening statement.

Almost 1 year ago, on March 4, 2020, the Committee on Homeland Security held a first Congressional hearing to examine the novel coronavirus that had begun spreading around the world. A week later, on March 11, 2020, the World Health Organization declared COVID–19 a global pandemic. Since then, over half a million Americans have died from the virus, a tragic, catastrophic loss of life. In remembrance of those who have lost their lives to COVID–19, I ask the committee to observe a moment of silence.

Thank you.

The committee is meeting today to examine perspectives on the COVID–19 pandemic 1 year later. We are fortunate to be joined today by witnesses representing 2 of the same organizations that came before the committee at our March 2020 hearing, and I look forward to resuming our discussion. Examining the failures in the Federal responses so far and applying lessons learned are essential to ending the pandemic and keeping Americans safe.

Unfortunately, President Trump ignored intelligence on COVID–19, made States compete for PPE and testing supplies, rejected

science on masking and distancing, silenced medical and scientific experts in his own administration, and failed to develop a comprehensive plan for testing and vaccine distribution. The American people have paid dearly for those failures and continue to do so today, in some cases with their lives.

Late last month, the Government Accountability Office released a scathing report on the Trump administration's persistent failure to address critical problems in the COVID–19 response. Nearly 90 percent of GAO's recommendations remain unimplemented as President Trump left office, leaving the normally reserved Government watch dog agency deeply troubled. Among the most significant failures identified was the lack of a comprehensive plan for COVID vaccine distribution. According to GAO, without a plan each State was left to create its own plan for locally distributing the shots and launching programs for getting them into people's arms. We all know how that is going. I doubt to say that every Member on this committee has received calls from constituents asking how and when can I get a shot. Long waits for appointments at under-resourced local public health departments, older people trying to navigate a patchwork of overwhelmed private pharmacy websites to get a shot, and minority and underserved communities being left behind, despite suffering disproportionate illness and death from the virus.

This is a situation the Biden administration was handed by its predecessor. President Biden has taken aggressive action to try to rectify these failures and bring the pandemic under control, but it will not be an easy task. Executing the National strategy for the COVID–19 response and pandemic preparedness will take a coordinated effort along Federal, State, local, Tribal, and territorial governments and private-sector partners.

I hope to hear from our witnesses today how Congress can be helpful in that endeavor. Getting the pandemic under control will also take addressing the disproportionate toll COVID–19 has taken on minority and underserved communities. The risk of dying from COVID is nearly 7 times higher in Hispanics and 5½ times higher in African Americans than others, yet minority and underserved communities are having trouble accessing life-saving COVID vaccines. In my State of Mississippi, only 20 percent of the vaccines have gone to African Americans, even though African Americans comprise 38 percent of the State's population. In one Mississippi county, less than 9 percent of vaccines have gone to African Americans even though 26 percent of residents are African American.

President Biden's Executive order and task force on COVID–19 health equity are a good start. But more needs to be done to ensure equitable vaccine access and outcomes.

I was heartened to hear of the creation of a civil rights advisory group within FEMA that will be working on this issue and Americans can be assured this committee will be conducting close oversight of their work and supporting their efforts. The Federal Government is paying for these vaccines with taxpayers' money and it must ensure that all Americans have equitable access to them.

I thank the witnesses for joining us and Members for their participation and look forward to a robust discussion.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

FEBRUARY 24, 2021

Almost 1 year ago, on March 4, 2020, the Committee on Homeland Security held the first Congressional hearing to examine the novel coronavirus that had begun spreading around the world. A week later, on March 11, 2020, the World Health Organization declared COVID–19 a global pandemic. Since then, over half a million Americans have died from the virus—a tragic, catastrophic loss of life.

In remembrance of those we have lost to COVID–19, I ask the committee to observe a moment of silence. Thank you.

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Unfortunately, President Trump ignored intelligence on COVID–19, made States compete for PPE and testing supplies, rejected science on masking and distancing, silenced medical and scientific experts in his own administration, and failed to develop comprehensive plans for testing and vaccine distribution. The American people have paid dearly for those failures and continue to do so today, in some cases with their lives.

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In my State of Mississippi, only 20 percent of vaccines have gone to African Americans, even though African Americans comprise 38 percent of the State's population. In one Mississippi county, less than 9 percent of vaccines have gone to African Americans even though 26 percent of residents are African American. President Biden's Executive Order and Task Force on COVID–19 Health Equity are a good start, but more needs to be done to ensure equitable vaccine access and outcomes.

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Chairman THOMPSON. With that, I recognize the Ranking Member, the gentleman from New York, Mr. Katko, for an opening statement.

You are going to have to unmute yourself.

Mr. KATKO. You had to me unmute me first, Mr. Chairman. I appreciate your comments.

Thank you for holding this necessary hearing today as well. I appreciate you tackling this topic so early in the proceedings. The mere fact that this hearing is being held virtually demonstrates the degree to which the COVID–19 pandemic has interrupted our daily lives. Like very few things during my lifetime, the COVID–19 pandemic has impacted every American in some way. It has had a crippling effect on our economy, forcing small businesses to shutter their doors, it has threatened the financial stability of millions of families, and it has taken a significant toll on the mental health of countless Americans, including our school children.

We need to do everything we can to support those suffering, including by taking appropriate steps to get our kids back in the classrooms as quickly and as safely as possible.

Not to mention the horrific number of deaths that have occurred. I saw media reports just last week that life expectancy in the United States fell by a full year in the first 6 months of 2020 resulting from the pandemic, with racial minorities, as you noted, suffering even greater declines. This is the largest drop since World War II and it is absolutely tragic. My thoughts and prayers go out to everyone who has suffered through this pandemic, especially those who have lost loved ones.

Sadly, a year later, when many of us thought we would have returned to a semblance of normalcy, we are still deep in the throes of this pandemic. Although it is a positive sign that cases and deaths may be trending down, at the moment the numbers are still way too high. Many have become numb to the news on any given day in the United States that thousands more of our fellow Americans have lost their lives to this devastating virus. Just last week alone we lost more than 10,000 Americans to COVID, and in the last few days surpassed 500,000 deaths totally. Luckily, the vaccines have given us some much-needed hope, but we are still a long way from the end. We need to do absolutely everything we can to get as many Americans vaccinated as quickly as possible.

Most of the news in 2020 surrounding the pandemic was awful, but I would be remiss for not mentioning that we saw enumerable feats of courage and perseverance. As we know, Mr. Chairman, the American people under the most horrendous conditions throughout history have always stepped up to defy the odds. Throughout the 2020 year, and continuing to this day, we see tremendous courage from health care workers and first responders on the front lines who continue to put their lives on the line to help their fellow Americans. I commend them for that.

Although the media tends to focus on the largest cities where the cases are higher, I would like to use this opportunity to highlight that the pandemic is everywhere. In districts like yours in Mississippi, Mr. Chairman, in mine in central New York. I would argue that the pandemic has had an even equal or even larger impact on our smaller cities and more rural communities.

I want to urge all those working on the response to the pandemic not to forget about the impact this deadly virus is having on communities in my district, such as Syracuse, New York, Auburn, New York, and Oswego, New York, and many, many others. In central New York we have seen the pandemic contribute to rising rates of

mental illness, substance use disorders, and nearly doubling the overdose stats for heroin.

My witness today will highlight some of those challenges. In my Congressional district we have seen north of 45,000 COVID cases and more than 800 deaths.

Even though the country has been given a ray of hope with the vaccine, there is much left to do, including—and I hate to say it because I hope it never happens—plan for the next pandemic. Now that we know first-hand that something like this is possible, we need to compile lessons learned and best practices to ensure we build an effective and aggressive strategy to respond to public health crises of this magnitude. Pandemic preparedness is a critical part of the Homeland Security mission. We must ensure that the Federal, State, local, and Tribal governments have diligent plans in place for a public health response to this and future pandemics.

Longer-term, we need to engage in a study about medical and pandemic response supply chains to identify where we are overly beholden to foreign nation-states, like China, that don't share our interests. I believe the Department can play a critical role in this work. Mr. Chairman, I see great opportunity, as always for bipartisan collaboration. We always accomplish the most when we work collaboratively across the aisle to address the needs of the American public.

Again, Mr. Chairman, thank you for holding this most important hearing today. I look forward to the testimony of our witnesses.

With that, I yield back.

[The statement of Ranking Member Katko follows:]

STATEMENT OF RANKING MEMBER JOHN KATKO

Thank you for holding this necessary hearing today. I appreciate your commitment to tackling this topic so early in the Congress. The mere fact that this hearing is being held virtually demonstrates the degree to which the COVID–19 pandemic has interrupted our daily lives.

Like very few things during my lifetime, the COVID–19 pandemic has impacted every American in some way—it has had a crippling effect on our economy forcing small businesses to shutter their doors, it has threatened the financial stability of millions of families, and it has taken a significant toll on the mental health of countless Americans, including our school children.

We need to do everything we can to support those suffering, including by taking appropriate steps to get our kids back in the classroom, as quickly and safely as possible!

Not to mention the horrific number of deaths that have occurred. I saw media reports just last week that life expectancy in the United States fell by a full year in the first 6 months of 2020 resulting from the pandemic, with racial minorities suffering even greater declines. This is the largest drop since World War II—and it's absolutely tragic. My thoughts and prayers go out to everyone who has suffered through this pandemic, especially those who have lost loved ones.

Sadly, a year later, when many of us thought we would have returned to a semblance of normalcy, we are still deep in the throes of this pandemic. Although it is a positive sign that cases and deaths may be trending down at the moment, the numbers are still way too high.

Many have become numb to the news on any given day in the United States, that thousands more of our fellow Americans have lost their lives to this devastating virus. Just last week alone, we lost more than 10,000 Americans to COVID and in the last few days surpassed 500,000 deaths total. Luckily, the vaccines have given us some much-needed hope, but we are still a long way from the end. We need to do absolutely everything we can to get as many Americans vaccinated as quickly as possible.

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ance. As we know, Mr. Chairman, the American people, under the most horrendous conditions throughout history, have always stepped up to defy the odds.

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I would argue that the pandemic has had an equal or even larger impact on our smaller cities and more rural communities.

I want to urge all those working on the response to the pandemic not to forget about the impact this deadly virus is having on communities such as Syracuse, Auburn, Oswego, and many, many others. In Central New York, we have seen the pandemic contribute to rising rates of mental illness, substance use disorders, and overdose deaths.

My witness today will highlight some of those challenges. In my Congressional district, we have seen north of 45,000 cases and more than 800 deaths.

Even though the country has been given a ray of hope with the vaccine, there is much left to do—including, and I hate to say it, plan for the next pandemic.

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Longer-term, we need to engage in a study of our medical and pandemic response supply chains to identify where we are overly beholden to foreign nation-states—like China—that don't share our interests. I believe the Department can play a critical role in this work, and Mr. Chairman, I see great opportunity for bipartisan collaboration on this.

We always accomplish the most when we work collaboratively, across the aisle to address the needs of the American people.

Again, Mr. Chairman, thank you for holding this hearing today. I look forward to the testimony of our witnesses.

Chairman THOMPSON. Other Members of the committee are reminded that under committee rules opening statements may be submitted for the record.

[The statement of Hon. Clyde follows:]

STATEMENT OF HON. ANDREW S. CLYDE

FEBRUARY 24, 2021

Thank you, Chairman Thompson.

I would like to take this opportunity to address my grave concern with the Biden administration's decision to eliminate the Migrant Protection Protocols. This reckless decision will have the dual effect of putting Americans at risk of exposure to the coronavirus and creating conditions that mirror the 2019 border crisis.

The increasing number of unaccompanied minors and families illegally crossing the border in the middle of a global pandemic is creating a recipe for disaster. President Biden's Executive actions have the potential to cause mass outbreaks at facilities and ports of entry, which would lead to temporary closures that could have a significant impact on commerce and further handicap our economic recovery efforts. A mass outbreak would also jeopardize the health and safety of our men and women who serve on the front lines protecting our Nation's borders. Finally, these Executive actions and a surge at the border have forced CBP officials to return to the dangerous policy of catch and release. This policy releases migrants who have not been properly vetted or sufficiently tested for coronavirus into our communities, putting the health and well-being of Americans at risk.

The Biden administration's actions are unacceptable and serve as distractions from what this committee should be focusing on, which is how we can secure our borders and prevent our constituents from being exposed to the COVID–19 virus. I would like to submit for the record a letter my colleagues and I on the House Oversight and Reform Committee sent to Secretary Mayorkas highlighting these concerns. With that Mr. Chairman, I yield back my time.

Chairman THOMPSON. Members are also reminded that the committee will operate according to the guidelines laid out by the Chairman and Ranking Member in our February 3 colloquy regarding remote procedures.

Now, I welcome our witnesses.

Ms. Nicole Clowers serves as the managing director of the Healthcare Team at the Government Accountability Office. She has been with GAO since 1998 and is one of the people leading GAO's reporting on the Federal Government's COVID–19 response.

Dr. Crystal Watson is a senior associate at John Hopkins Center for Health Security and assistant professor in the Department of Environmental Health and Engineering. Her policy research focuses on public health, risk assessment, prices, and risk-based decision making regarding preparedness and response, biodefense, and emerging infectious diseases.

Dr. Ngozi Ezike is the director of Illinois Department of Public Health. She is a board-certified internist and pediatrician and the testimony she provided to the committee 1 year ago was invaluable to our understanding of a difficult road ahead. I thank her for agreeing to return today.

I would now like to recognize the Ranking Member for the purposes of introducing our fourth witness.

Mr. KATKO. Thank you, Mr. Chairman.

My witness' name is a little bit easier. His name is Ryan McMahon. I am proud to introduce a constituent by Mr. Ryan McMahon. Ryan is an Onondaga County executive and has been so since 2018. He started his career in public service as Syracuse city counselor in 2005 after being elected at the ripe old age of 25. He was reelected in 2007 for a second term and quickly distinguished himself as a bipartisan problem solver.

In 2011 County Executive McMahon was elected to the 15th District of the county legislature of Onondago, which includes portions of the city of Syracuse, the Town of Geddes, and the Town of Onondaga. Ryan was subsequently elected chairman of the county leg in 2012 by his fellow legislators, becoming the youngest chairman in county history.

Upon taking office as county executive, Ryan McMahon has placed a focus on 3 main initiatives, poverty, infrastructure, and economic development. Obviously, Mr. Chairman, Ryan's main focus now is COVID. He has done a remarkable job leading us through this pandemic in central New York and saw daily briefings that have been superb. I commend him for his leadership in that regard.

I have enjoyed working with Mr. McMahon during my life in the House and I am thrilled that he is able to testify with us today.

With that, Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you. Without objection, the witnesses' full statements will be inserted in the record.

I now ask Ms. Clowers to summarize her statement for 5 minutes.

STATEMENT OF A. NICOLE CLOWERS, MANAGING DIRECTOR, HEALTH CARE TEAM, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO)

Ms. CLOWERS. Thank you, Chairman Thompson, Ranking Member Katko, and Members of the committee. Thank you for the opportunity to discuss the Federal Government's on-going response to COVID–19.

Through the CARES Act Congress directed GAO to provide on-going real time oversight of the Federal Government's response to the pandemic. As of January we have issued 5 reports containing 44 recommendations. About a third of those recommendations were directed in the following public health areas, COVID testing, vaccine distribution, medical supply chain, COVID health disparities, and COVID data. My written statement details each of those recommendations. We believe each, if fully implemented, would improve the on-going Federal response.

In my comments this morning I would like to focus on 3 of those areas, vaccine distribution, the medical supply chain, and COVID disparities.

First, the topic that is on everyone's mind, vaccine distribution. As you know, as of today 2 vaccines have been authorized for emergency use and are being distributed. The emergency use authorization request for a third vaccine candidate is pending before the FDA. The rapid development of these vaccines is an achievement. But as we and others have reported, the distribution of the vaccines had not met expectations through January. While the distribution pace has recently increased, challenges continue to be reported. Distribution of authorized vaccines across the Nation is a daunting, complicated logistical endeavor in part because of the number of entities involved across all levels of the Government and the private and non-profit sectors. This is why we recommended in September 2020 that HHS, as part of a National plan for distributing and administering the vaccine, outline an approach for how efforts would be coordinated across Federal and non-Federal partners. To date this recommendation has not been fully implemented and we maintain doing so, especially ensuring local officials are part of the planning efforts, would improve the Nation's distribution efforts.

The second topic that I would like to highlight is the medical supply chain. The pandemic has highlighted vulnerabilities in the Nation's medical supply chain, which includes personal protective equipment and other supplies necessary to treat individuals with COVID and to vaccinate people. Providing medical supplies to meet the continuing needs has been a persistent challenge.

We have made multiple recommendations to improve the Federal Government's management of the medical supply chain. For example, we recommended that HHS should develop plans outlining specific actions the Federal Government would take to mitigate medical supply gaps for the duration of the pandemic. We also recommended that HHS work with Federal and non-Federal stakeholders to helps States enhance their ability to track the status of supply requests. Implementing both of these recommendations would help address the supply challenges.

Finally, I want to highlight the health care disparities related to COVID–19. Available data from CDC and others show communities of color bear a disproportional burden of COVID–19, to include cases, hospitalizations, and death. For example, available data show that the rate of COVID–19 hospitalizations for Native Americans is almost 4 times the rate for White Americans.

While CDC collects race and ethnicity data on indicators of COVID–19, we found gaps in the data. For example, data on race and ethnicity for COVID–19 vaccine recipients were missing for almost half of the recipients who received at least one dose. The lack of complete race and ethnicity data hinders the Government's ability to take corrective actions.

In conclusion, over the past 2 weeks case counts and deaths have thankfully slowed since peaking in January, but public health officials caution that we should not become complacent in our efforts as new variants emerge. Until the country better contains the spread of the virus, the pandemic will continue to lay bare the fragmented nature of the public health sector, the fragility of the medical supply chain, and long-standing disparities in health care access, treatment, and outcomes.

Chairman Thompson, Ranking Member Katko, and Members of the committee, this concludes my prepared statement. I would be happy to answer questions at the appropriate time.

Thank you.

[The prepared statement of Ms. Clowers follows:]

PREPARED STATEMENT OF A. NICOLE CLOWERS

FEBRUARY 24, 2021

HIGHLIGHTS

Highlights of GAO–21–396T, a testimony before the Committee on Homeland Security, House of Representatives.

Why GAO Did This Study

As of February 17, 2021, the United States had about 27 million cumulative reported cases of COVID–19 and more than 486,000 reported deaths, according to the Centers for Disease Control and Prevention. The country also continues to experience serious economic repercussions.

Five relief laws, including the CARES Act, have appropriated $3.1 trillion to address the public health and economic threats posed by COVID–19. The CARES Act also includes a provision for GAO to report on its on-going monitoring and oversight efforts related to COVID–19.

This testimony summarizes GAO's insights from its oversight of the Federal Government's pandemic response in a series of comprehensive reports issued from June 2020 through January 2021. In particular, the statement focuses on the public health response, including testing, vaccines and therapeutics, medical supply chain, health disparities, and health data.

GAO reviewed data, documents, and guidance from Federal agencies about their activities and interviewed Federal and State officials and stakeholders for the series of reports on which this testimony is based. See *https://www.gao.gov/coronavirus/*.

What GAO Recommends

GAO has made 44 recommendations for agencies and 4 matters for Congressional consideration in its comprehensive series of bimonthly reports on the Federal response to COVID–19 over the last year. GAO will issue its next report in this series in March 2021.

COVID–19.—KEY INSIGHTS FROM GAO'S OVERSIGHT OF THE FEDERAL PUBLIC HEALTH RESPONSE

What GAO Found

More than a year after the United States declared COVID–19 a public health emergency, the pandemic continues to result in catastrophic loss of life and substantial damage to the economy. It also continues to lay bare the fragmented nature of our public health sector, the fragility of the Nation's medical supply chain, and long-standing disparities in health care access, treatment, and outcomes.

GAO has made 44 recommendations to Federal agencies. Of these recommendations, 16 relate to the following public health topics:

COVID–19 Testing.—GAO has made 2 recommendations to date to improve the Federal Government's efforts in diagnostic testing for COVID–19, critical to controlling the spread of the virus. In January 2021, GAO recommended that the Department of Health and Human Services (HHS) develop and make publicly available a comprehensive National COVID–19 testing strategy.

Vaccines and Therapeutics.—GAO has made 2 recommendations to improve transparency, communication, and coordination around the Government's efforts to develop, manufacture, and distribute vaccines and therapeutics to prevent and treat COVID–19. For example, in September 2020, GAO recommended that HHS establish a time frame for a National vaccine distribution and administration plan that follows best practices, with Federal and non-Federal coordination.

Medical Supply Chain.—GAO has made 7 recommendations for the Federal Government to respond to vulnerabilities highlighted by the pandemic in the Nation's medical supply chain, including limitations in personal protective equipment and other supplies necessary to treat individuals with COVID–19. In January 2021, GAO recommended that HHS establish a process for regularly engaging with Congress and non-Federal stakeholders as the agency refines and implements its supply chain strategy for pandemic preparedness, to include the role of the Strategic National Stockpile.

COVID–19 Health Disparities.—GAO has made 3 recommendations to improve COVID–19 data by race and ethnicity, as available data show communities of color bear a disproportionate burden of COVID–19 positive tests, cases, hospitalizations, and deaths. In September 2020, GAO recommended that the Centers for Disease Control and Prevention involve key stakeholders to help ensure the complete and consistent collection of demographic data.

COVID–19 Data.—GAO has made 2 recommendations to improve the collection of data needed to respond to COVID–19 and prepare for future pandemics. GAO recommended in January 2021 that HHS establish an expert committee to help systematically define and ensure the collection of standardized data across the relevant Federal agencies and related stakeholders; the absence of such data hinders the ability of the Government to respond to COVID–19, communicate the status of the pandemic with citizens, or prepare for future pandemics.

Although the responsible agencies generally agreed with the majority of the 16 recommendations, only 1 has been fully implemented. GAO maintains that implementing these recommendations will improve the Federal Government's public health response and ability to recover as a Nation.

Chairman Thompson, Ranking Member Katko, and Members of the committee: Thank you for the opportunity to discuss the Federal Government's on-going response to Coronavirus Disease 2019 (COVID–19). The pandemic has resulted in catastrophic loss of life and substantial damage to the global economy, and to the stability and security of our Nation. As of February 17, 2021, the United States had more than 27 million reported cases and 486,000 reported deaths, according to the Centers for Disease Control and Prevention (CDC).

The country also continues to experience serious economic repercussions. In January 2021, there were more than 10.1 million unemployed individuals, compared to nearly 5.8 million individuals in January 2020.

Over the past 2 weeks, case counts and deaths have slowed since peaking in January 2021. But public health officials warn that we should not become complacent in our efforts, as new variants of virus appear across the country. Until the country better contains the spread of the virus, the pandemic will continue to lay bare the fragmented nature of our public health sector, the fragility of our medical supply chain, and long-standing disparities in health care access, treatment, and outcomes, as well as impeding a more robust economic recovery.

In response to this on-going public health emergency, and the resulting economic challenges, Congress and the administration have taken a series of actions to protect the health and well-being of Americans. Notably, in March 2020, Congress passed, and the President signed into law, the CARES Act, which provided over $2

trillion in emergency assistance and health care response for individuals, families, and businesses affected by COVID–19.[1] To date, the 5 enacted COVID–19 relief laws, including the CARES Act, have appropriated $3.1 trillion.

The CARES Act includes a provision for us to conduct monitoring and oversight of the Federal Government's efforts to prepare for, respond to, and recover from the COVID–19 pandemic, including issuance of bi-monthly reports to Congress.[2] We are to report on, among other things, the effect of the pandemic on public health and the economy. To date, our work in response to this provision includes 5 comprehensive issued reports from June 2020 through January 2021; we will issue our next Government-wide report on the Federal response to the COVID–19 pandemic at the end of March.

In our 5 reports we have made 44 recommendations to Federal agencies, and raised 4 matters for Congressional consideration to improve the Federal Government's response efforts.[3] Our recommendations are tailored to specific Federal programs and initiatives, and, if implemented, will strengthen the efficiency, effectiveness, and accountability of these Federal efforts. We urge the new Congress and administration to consider these recommendations as well as the principles of an effective Federal response that we have previously identified.

My comments today will summarize the key findings and recommendations from our oversight of the Federal Government's continued efforts to respond to and recover from the COVID–19 pandemic. I will focus my comments on our findings related to the public health response, including COVID–19 testing, vaccines and therapeutics, the medical supply chain, COVID–19 health disparities, and COVID–19 health data.

We conducted the work on which this statement is based, which was completed on January 15, 2021, with updates to Federal agency data, as available, in accordance with generally accepted Government auditing standards.[4] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

KEY INSIGHTS FROM GAO'S OVERSIGHT OF THE FEDERAL RESPONSE TO COVID–19

In February 2020, at the outset of the COVID–19 pandemic, we identified key principles that are essential for an effective Federal response.[5] Specifically, based on our prior work examining responses to large-scale catastrophic disasters or public health emergencies, we emphasized the need for Federal agencies to coordinate, establish, and define roles and responsibilities among those responding to the crisis, and to provide clear, consistent communication. In June 2020, we reinforced the importance of these key principles and also emphasized the need to collect and analyze data to inform decision making and future preparedness; establish clear goals; establish mechanisms for accountability and transparency to help ensure program integrity; and address fraud risks. Incorporating these principles into on-going or new COVID–19-related programs and policies will improve the effectiveness of the Federal Government's response.

Of the 44 recommendations we have made to date, 16 fall into one of the following public health areas: COVID–19 testing, vaccines and therapeutics, medical supply chain, COVID–19 health disparities, and COVID–19 health data.

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[1] Pub. L. No. 116–136, 134 Stat. 281 (2020). As of January 1, 2021, 4 other relief laws were also enacted in response to the COVID–19 pandemic: The Consolidated Appropriations Act, 2021, Pub. L. No. 116–260, 134 Stat. 1182 (2020); Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116–139, 134 Stat. 620 (2020); Families First Coronavirus Response Act, Pub. L. No. 116–127, 134 Stat. 178 (2020); and the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116–123, 134 Stat. 146. We refer to these 5 laws, each of which was enacted as of January 1, 2021, and provides appropriations for the COVID–19 response, as "COVID–19 relief laws," and the funding appropriated by these laws as "COVID–19 relief funds." In January 2020, the novel coronavirus was declared a public health emergency.

[2] Pub. L. No. 116–136, § 19010, 134 Stat. at 579–81.

[3] See *https://www.gao.gov/coronavirus/* for our comprehensive reports and other COVID–19-related reports.

[4] We reviewed data, documents, and guidance from Federal agencies about their activities and interviewed Federal and State officials and stakeholders for the series of reports on which this testimony is based.

[5] A. Nicole Clowers, Managing Director of GAO's Health Care team, *Roundtable: Are We Prepared? Protecting the U.S. from Global Pandemics,* testimony before the Senate Committee on Homeland Security and Governmental Affairs. 116th Cong., 2d sess., Feb. 12, 2020.

COVID–19 Testing

Diagnostic testing for COVID–19 is critical to controlling the spread of the virus, according to CDC. We have made 2 recommendations to improve the Federal Government's COVID–19 testing efforts, as shown in table 1. Most recently, in January 2021, we found that the Department of Health and Human Services (HHS) had not issued a comprehensive and publicly available National testing strategy. For example, stakeholders involved in the response efforts told us that they either were unaware of the National strategy or did not have a clear understanding of it. Without a comprehensive, publicly-available National strategy, HHS is at risk of key stakeholders and the public lacking crucial information to support an informed and coordinated testing response.

In January 2021, we recommended that HHS develop and make publicly available a comprehensive National COVID–19 testing strategy that incorporates all 6 characteristics of an effective National strategy. Such a strategy could build upon existing strategy documents that HHS has produced for the public and Congress to allow for a more coordinated pandemic testing approach. (See table 1.)

TABLE 1: GAO'S RECOMMENDATIONS RELATED TO COVID–19 TESTING

Recommendation	Status
The Secretary of Health and Human Services (HHS) should develop and make publicly available a comprehensive National COVID–19 testing strategy that incorporates all 6 characteristics of an effective National strategy. Such a strategy could build upon existing strategy documents that HHS has produced for the public and Congress to allow for a more coordinated pandemic testing approach (January 2021 report).	Open. HHS partially concurred with our recommendation. HHS agreed that the Department should take steps to more directly incorporate some of the elements of an effective National strategy, but expressed concern that producing such a strategy at this time could be overly burdensome on the Federal, State, and local entities that are responding to the pandemic, and that a plan would be outdated by the time it was finalized or potentially rendered obsolete by the rate of technological advancement.
The Secretary of Health and Human Services should ensure that the director of the Centers for Disease Control and Prevention (CDC) clearly discloses the scientific rationale for any change to testing guidelines at the time the change is made (November 2020 report).	Open. HHS concurred with our recommendation, noting that CDC officials typically consult with scientific stakeholders when issuing guidance and that HHS will continue to evaluate its processes in this area.

Source GAO/GAO–21–396T.

Vaccines and Therapeutics

Multiple Federal agencies support the development and manufacturing, and now distribution, of vaccines and therapeutics to prevent and treat COVID–19. Agencies involved in the Federal partnership (formerly called Operation Warp Speed) include the Department of Defense (DOD) and HHS, including HHS's Biomedical Advanced Research and Development Authority (BARDA), Food and Drug Administration (FDA), CDC, and the National Institutes of Health (NIH). DOD is supporting HHS in Nation-wide distribution efforts of any licensed or authorized vaccine. As of February 18, 2021, 2 of the 6 Operation Warp Speed vaccine candidates had been authorized by FDA for emergency use, and vaccine distribution and vaccine administration began in December 2020. A third company submitted a request for emergency use authorization for its vaccine to FDA on February 4, 2021.

In addition, the Federal Emergency Management Agency (FEMA) provides funding to States (including the District of Columbia), Tribes and territories, for expenses related to COVID–19 vaccination. In accordance with a January 21, 2021, Presidential memorandum, FEMA will reimburse States, territorial, local, and Tribal governments for costs associated with vaccine distribution and administration through the Disaster Relief Fund, which had a balance of more than $12.2 billion,

as of February 7, 2021, according to FEMA.[6] The agency has also deployed staff across the Nation to support vaccine centers with Federal personnel and technical assistance.

As shown in table 2, we have made 2 recommendations to improve the Government's efforts related to vaccines and therapeutics. In particular, in September 2020, we reported that clarity on the Federal Government's plans for distributing and administering vaccine, as well as timely, clear, and consistent communication to stakeholders and the public about those plans, is essential. In September 2020, we recommended that HHS, with the support of DOD, establish a time frame for documenting and sharing a National plan for distributing and administering COVID–19 vaccines that, among other things, outlines an approach for how efforts would be coordinated across Federal agencies and non-Federal entities.

In our January 2021 report, we noted that vaccine distribution and administration had, as of January, fallen short of expectations. We reiterated the importance of fully implementing our September 2020 recommendation. (See table 2.)

TABLE 2: GAO'S RECOMMENDATIONS RELATED TO COVID–19 VACCINES AND THERAPEUTICS

Recommendation	Status
The Secretary of Health and Human Services should direct the Commissioner of the Food and Drug Administration (FDA) to identify ways to uniformly disclose to the public the information from FDA's scientific review of safety and effectiveness data—similar to the public disclosure of the summary safety and effectiveness data supporting the approval of new drugs and biologics—when issuing emergency use authorizations (EUA) for therapeutics and vaccines, and, if necessary, seek the authority to publicly disclose such information (November 2020 report on vaccine and therapeutics).	Closed. FDA developed a process for working with drug sponsors to disclose its scientific review documents for therapeutic EUAs and has released this information for the EUAs it has already issued. For vaccine EUAs, FDA is holding public Vaccines and Related Biological Products Advisory Committee meetings, through which FDA and sponsors are making information from scientific reviews publicly available. The agency also released decision memos with detailed information about the agency's review of safety and effectiveness data for the 2 vaccines authorized to date.
The Secretary of Health and Human Services, with support from the Secretary of Defense, should establish a time frame for documenting and sharing a National plan for distributing and administering a COVID–19 vaccine and, in developing such a plan, ensure that it is consistent with best practices for project planning and scheduling and outlines an approach for how efforts will be coordinated across Federal agencies and non-Federal entities (September 2020 report).	Open. The Department of Health and Human Services (HHS) neither agreed nor disagreed with our recommendation. In November 2020, we reported that HHS and the Department of Defense had released initial planning documents for the distribution and administration of potential COVID–19 vaccines, but also reported that stakeholders indicated that they would like to see additional information as planning continued.

Source GAO Analysis/GAO–21–396T.

Medical Supply Chain

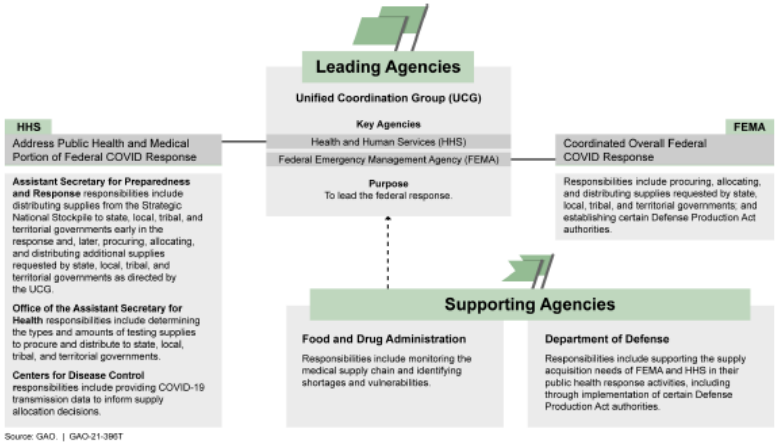
The pandemic has highlighted vulnerabilities in the Nation's medical supply chain, which includes personal protective equipment and other supplies necessary to treat individuals with COVID–19. Ensuring the availability of medical supplies to meet the continuing needs of State, local, Tribal, and territorial governments, as

[6] White House, *Memorandum to Extend Federal Support to Governors' Use of the National Guard to Respond to COVID–19 and to Increase Reimbursement and Other Assistance Provided to States,* (Washington, DC: Jan. 21, 2021), accessed on February 4, 2021, *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/extend-federal-support-to-governors-use-of-national-guard-to-respond-to-covid-19-and-to-increase-reimbursement-and-other-assistance-provided-to-states/*. According to FEMA, as of February 7, 2021, it had provided more than $2.29 billion to 32 States, the District of Columbia, 3 territories, and 2 Tribes for expenses related to COVID–19 vaccination efforts.

well as point-of-care providers, such as nursing homes, has been a persistent challenge for Federal agencies. Continued supply chain constraints may also hamper HHS's goal of building a 90-day supply of certain key items in the Strategic National Stockpile (SNS).

Multiple Federal agencies have responsibility for coordinating and managing the medical supply chain, and HHS and FEMA lead the Federal response through the Unified Coordination Group.[7] HHS is designated as the lead agency to address the public health and medical portion of the response and FEMA is designated as the lead agency for coordinating the overall Federal response. The agencies are responsible for supporting and informing decisions made by the Unified Coordination Group regarding the allocation, distribution, and procurement of COVID-related supplies (see fig. 1).

Figure 1: Key Federal Agencies Involved in Coordinating and Managing the Medical Supply Chain during the COVID-19 Pandemic



Source: GAO. | GAO-21-386T

We have made 7 recommendations to improve the Federal Government's efforts to address medical supply challenges highlighted by the pandemic (see table 3.) In our January 2021 report, we focused on the role of the SNS, which is an important piece of HHS's strategy to improve the medical supply chain to enhance pandemic response capabilities and was being finalized during the course of our review. However, the Department has yet to develop a process for engaging about the strategy with key non-Federal stakeholders that have a shared role for providing supplies during a pandemic, such as State and territorial governments and the private sector. Our work has noted the importance of directly and continuously involving key stakeholders, including Congress, in the development of successful agency reforms and in helping to harness ideas, expertise, and resources.

In January 2021, we recommended that HHS establish a process for regularly engaging with Congress and non-Federal stakeholders—including State, local, Tribal, and territorial governments and private industry—as the agency refines and implements its supply chain strategy for pandemic preparedness, to include the role of the SNS.

[7] The Unified Coordination Group (UCG) is the primary field entity for the Federal response. The group integrates diverse Federal authorities and capabilities and coordinates Federal response and recovery operations. The UCG is jointly led by the administrator of FEMA, the assistant secretary for preparedness and response, and a representative of CDC.

TABLE 3: GAO RECOMMENDATIONS RELATED TO MEDICAL SUPPLY CHAIN CHALLENGES

Recommendation	Status
To improve the Nation's response to and preparedness for pandemics, the assistant secretary for preparedness and response should establish a process for regularly engaging with Congress and non-Federal stakeholders—including State, local, Tribal, and territorial governments and private industry—as the Department of Health and Human Services (HHS) refines and implements a supply chain strategy for pandemic preparedness, to include the role of the Strategic National Stockpile (January 2021 report).	Open. HHS generally concurred with our recommendation, and added that improving the pandemic response capabilities of State, local, Tribal, and territorial governments is a priority.
The assistant secretary for preparedness and response, in coordination with the appropriate offices within HHS, should accurately report data in the Federal procurement database system and provide information that would allow the public to distinguish between spending on other transaction agreements and procurement contracts (January 2021 report).	Open. HHS concurred with our recommendation and stated that it has taken steps to manually identify its other transaction agreements in its contract writing system to allow the public to distinguish between spending on agreements and procurement contracts in the Federal Procurement Data System—Next Generation. HHS also plans to update its contract writing system.
The Commissioner of the Food and Drug Administration (FDA) should, as the agency makes changes to its collection of drug manufacturing data, ensure the information obtained is complete and accessible to help it identify and mitigate supply chain vulnerabilities, including by working with manufacturers and other Federal agencies (e.g., the Departments of Defense and Veterans Affairs), and, if necessary, seek authority to obtain complete and accessible information (January 2021 report).	Open. HHS neither agreed nor disagreed with our recommendation. In HHS's response, FDA said that as the agency continues efforts to enhance relevant authorities and close data gaps, it will consider GAO's recommendation.
The Secretary of Health and Human Services, in coordination with the administrator of the Federal Emergency Management Agency (FEMA)—who head agencies leading the COVID–19 response through the Unified Coordination Group—should immediately document roles and responsibilities for supply chain management functions transitioning to the Department of Health and Human Services, including continued support from other Federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain, and address emergent supply issues for the duration of the COVID–19 pandemic (September 2020 report).	Open. HHS disagreed with our recommendation at the time the report was issued and noted, among other things, the work that the Department had done to manage the medical supply chain and increase supply availability.

TABLE 3: GAO RECOMMENDATIONS RELATED TO MEDICAL SUPPLY CHAIN CHALLENGES—Continued

Recommendation	Status
The Secretary of Health and Human Services in coordination with the administrator of FEMA—who head agencies leading the COVID–19 response through the Unified Coordination Group—should further develop and communicate to stakeholders plans outlining specific actions the Federal Government will take to help mitigate remaining medical supply gaps necessary to respond to the remainder of the pandemic, including through the use of Defense Production Act authorities (September 2020 report).	Open. HHS disagreed with our recommendation at the time the report was issued and noted, among other things, the work that the Department had done to manage the medical supply chain and increase supply availability.
The Secretary of Health and Human Services—who heads one of the agencies leading the COVID–19 response through the Unified Coordination Group—consistent with the Department's roles and responsibilities, should work with relevant Federal, State, territorial, and Tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help States enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID–19 pandemic response (September 2020 report).	Open. HHS disagreed with our recommendation at the time the report was issued and noted, among other things, the work that the Department had done to manage the medical supply chain and increase supply availability.
The administrator of FEMA—who heads one of the agencies leading the COVID–19 response through the Unified Coordination Group—consistent with the Department's roles and responsibilities, should work with relevant Federal, State, territorial, and Tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help States enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID–19 pandemic response (September 2020 report).	Open. The Department of Homeland Security, on behalf of FEMA, disagreed with our recommendation at the time the report was issued and noted, among other things, the work that the Department had done to manage the medical supply chain and increase supply availability

Source GAO/GAO–21–396T.

COVID–19 Health Disparities

Available data from CDC and others demonstrate disparities in COVID–19 indicators by race and ethnicity, with communities of color bearing a disproportionate burden of COVID–19 cases, hospitalizations, and deaths. For example, the available data on COVID–19 hospitalizations show that as of February 12, 2021, the rate of COVID–19-associated hospitalizations for non-Hispanic American Indian/Alaska Native persons is 3.7 times the rate for non-Hispanic White persons, when adjusting for age.[8] Available data from CDC on the percentage of positive COVID–19 tests

[8] Hospitalization data through January 30, 2021, are from CDC's COVID–19-Associated Hospitalization Surveillance Network (COVID–NET), which collects data on COVID–19 hospitalizations that are confirmed by laboratory testing from select counties in 14 States, representing 10 percent of the U.S. population. It includes data from hospitals in select counties in California, Colorado, Connecticut, Georgia, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York,

and on recipients of COVID–19 vaccinations also demonstrate racial and ethnic disparities.

Testing.—As of January 7, 2021, among COVID–19 diagnostic test results reported to CDC from laboratories in 48 jurisdictions, the percent of tests that were positive by each racial and ethnic group was: 17.9 percent for Hispanic or Latino persons, 13.2 percent for non-Hispanic Native Hawaiian or Other Pacific Islander persons, 12.4 percent for non-Hispanic American Indian/Alaska Native, and 11.2 percent for non-Hispanic Black persons, compared to 9.5 percent for non-Hispanic White persons.[9]

Vaccinations.—Data showed disparities by race and ethnicity in vaccine recipients who received at least one dose whose race and ethnicity was known as of February 8, 2021:

- 62.9 percent were non-Hispanic White (compared to 60.1 percent of the U.S. population),
- 8.9 percent were Hispanic or Latino (compared to 18.5 percent of the U.S. population), and
- 5.9 percent were non-Hispanic Black (compared to 13.4 percent of the U.S. population).[10]

While CDC collects and makes race and ethnicity data on indicators of COVID–19 available to the public, we found gaps in the data for COVID–19 indicators. For example, as of February 2, 2021, race and ethnicity was missing for 48.8 percent of COVID–19 cases with case report forms received by CDC, or 61.5 percent of total cases reported.[11] Additionally, as of February 8, 2021, data collected from States and jurisdictions on race and ethnicity for COVID–19 vaccine recipients were missing for almost half (45.6 percent) of recipients who received at least 1 dose.

We made 3 recommendations to address the gaps in race and ethnicity data (see table 4). CDC agreed with the recommendations.

Ohio, Oregon, Tennessee, and Utah. American Indian/Alaska Native, Asian, and Black, and White persons were non-Hispanic. Hispanic or Latino persons might be of any race.

Age-adjusted case, hospitalization, and death rates were standardized to the 2019 U.S. intercensal population. Age-adjusted rates, which hold constant the age distributions between different population groups, allow researchers to focus analyses on other demographics, such as race and ethnicity, without being concerned about differences that are due to different age distributions of the racial and ethnic groups. Age-adjusted rates are particularly important to consider for indicators of COVID–19 because persons in older age groups are more likely to experience hospitalizations and racial and ethnic groups have different age distributions in the U.S. population.

[9] Department of Health and Human Services, Centers for Disease Control and Prevention. Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID–19) Testing, 8th 30-Day Update (January 2021). CDC data represent viral COVID–19 laboratory test results from laboratories in the United States, including commercial laboratories, public health laboratories, and other testing locations from 48 jurisdictions. The data represent total laboratory tests, not individual people, and exclude antibody and antigen tests.

[10] CDC COVID Data Tracker, *https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic,* accessed February 9, 2021.

[11] CDC officials reported that the number of cases with case report forms received by CDC is less than the total number of reported cases because there is generally a 2-week lag from when total cases are reported by State and jurisdictional health departments to when CDC receives the case report forms. Total cases reported by CDC include both probable and confirmed cases as reported by States or jurisdictions. A probable case does not have confirmatory laboratory evidence, but meets certain other criteria.

TABLE 4: GAO'S RECOMMENDATIONS RELATED TO COVID–19 HEALTH DISPARITIES

Recommendation	Status
As the Center for Disease Control and Prevention (CDC) implements its COVID–19 Response Health Equity Strategy, the director of CDC should determine whether having the authority to require States and jurisdictions to report race and ethnicity information for COVID–19 cases, hospitalizations, and deaths is necessary for ensuring more complete data and, if so, seek such authority from Congress (September 2020 report).	Open. CDC agreed with our recommendation. In response to our recommendation, CDC stated in January 2021 that the agency is committed to having discussions, both internally and with stakeholders, to assess whether having and implementing authority to require States and jurisdictions to report race and ethnicity information for COVID–19 cases would result in improved reporting.
As CDC implements its COVID–19 Response Health Equity Strategy, the director of CDC should involve key stakeholders to help ensure the complete and consistent collection of demographic data (September 2020 report).	Open. CDC agreed with our recommendation. In response to our recommendation, CDC stated in January 2021 that the agency is working with State and local health departments, in addition to other stakeholders, to accelerate the reporting of demographic data and improve data quality, including for information on race and ethnicity.
As CDC implements its COVID–19 Response Health Equity Strategy, the director of CDC should take steps to help ensure CDC's ability to comprehensively assess the long-term health outcomes of persons with COVID–19, including by race and ethnicity (September 2020 report).	Open. CDC agreed with our recommendation. In response to our recommendation, CDC noted in October 2020 that the agency is convening a team to develop a plan to monitor the long-term health outcomes of persons with COVID–19 by identifying health care surveillance systems that can electronically report health conditions to State and local health departments.

Source GAO/GAO–21–396T.

COVID–19 Data Collection and Standardization

The Federal Government does not have a process to help systematically define and ensure the collection of standardized data across relevant Federal agencies and related stakeholders to help respond to COVID–19, communicate the status of the pandemic with citizens, or prepare for future pandemics. As a result, COVID–19 information that is collected and reported by States and other entities to the Federal Government is often incomplete and inconsistent.

The lack of complete and consistent data limits HHS's and others' ability to monitor trends in the burden of the pandemic across States and regions, make informed comparisons between such areas, and assess the impact of public health actions to prevent and mitigate the spread of COVID–19. Further, incomplete and inconsistent data have limited HHS's and others' ability to prioritize the allocation of health resources in specific geographic areas or among certain populations most affected by the pandemic. For example, HHS's data on COVID–19 in nursing homes do not capture the first 4 months of the pandemic, because the agency did not require nursing homes to report until May 8, 2020. The gaps in reporting limits the usefulness of data in helping to understand the effects of COVID–19 in nursing homes. GAO has made 2 recommendations to improve the collection of data needed to respond to COVID–19 and prepare for future pandemics.

In January 2021, we recommended that HHS immediately establish an expert committee comprised of knowledgeable health care professionals from the public and private sectors, academia, and nonprofits or use an existing one to systematically review and inform the alignment of on-going data collection and reporting standards for key health indicators.

In addition, in September 2020, we recommended that HHS, in consultation with CMS and CDC, develop a strategy to capture more complete data on COVID–19 cases and deaths in nursing homes retroactively back to January 1, 2020.

In conclusion, we have made 16 recommendations to improve the Government's pandemic response in the areas of COVID–19 testing, vaccines and therapeutics, medical supply chain, COVID–19 health disparities, and COVID–19 health data. Most of the recommendations have not been implemented. We maintain that doing so would improve the Government's response. We will continue to monitor the implementation of our past recommendations as part of our on-going oversight of the Government's COVID–19 response and recovery efforts on behalf of Congress.

Chairman Thompson, Ranking Member Katko, and Members of the committee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

Chairman THOMPSON. Thank you very much.

Now I ask Dr. Watson to summarize her statement for 5 minutes.

STATEMENT OF CRYSTAL R. WATSON, DR PH, SENIOR SCHOLAR, JOHNS HOPKINS CENTER FOR HEALTH SECURITY, AND ASSISTANT PROFESSOR, DEPARTMENT OF ENVIRONMENTAL HEALTH AND ENGINEERING, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Ms. WATSON. Mr. Chairman, Ranking Member Katko, and Members of the committee, thank you very much for the opportunity to testify to you today.

One year ago the director of our center, Dr. Tom Inglesby, testified to this committee about the grave threat of COVID–19 and the need for a robust response. There was significant uncertainty at that time about how the pandemic would play out.

Today we have answers to many of the early unknowns and are now vaccinating millions of Americans per day, but on balance our National response has not met its potential and many thousands of deaths have occurred unnecessarily as a result.

As has been said, we have just reached a terrible total of half a million deaths Nation-wide. More Americans have now died from COVID–19 than in all 20th Century wars combined. Despite having only 4 percent of the world's population, our country has contributed 25 percent of the global total of cases and 21 percent of reported deaths. These are just the officially reported statistics. The true burden of COVID–19 is unknown, but is estimated to be much higher than what is recorded.

As has been stated already, the consequences of the pandemic have been appalling unequal. When adjusted for age, people of color and indigenous people have been over twice as likely to die from COVID.

Yet while the last year has been a nightmare, there are now some glimmers of hope. The number of U.S. cases, hospitalizations, and deaths are all dropping rapidly from the winter peak. I expect that this trend will continue due to a combination of mitigation measures and vaccinations. While the vaccine roll-out has been anything but smooth, it is improving. The emergence of consequential SARS–CoV variants of concern are troubling, but I am hopeful that vaccination and current mitigation measures will prevent a severe resurgence in the United States this spring. However, it is something that we obviously have to watch very closely.

Vaccination is the centerpiece of the current U.S. response, but it is also important to note that low- and middle-income countries are mostly still waiting for a vaccine. This is a humanitarian crisis

for those countries, and it also represents a significant risk for the world because it could prolong the pandemic.

Now, I would like to take a few moments to briefly highlight some of the successes and failure of the U.S. response over the last year. First, the successes. It is so important to recognize that the response represents collective work from tens of thousands of people across the country. We should be truly thankful for the heroic efforts of those who have worked to reduce the [inaudible]. Of course, the biggest and most visible success over the past year has been the development of multiple highly safe and effective vaccines and therapeutics. I can't emphasis enough what a technical feat this is.

Now, to the challenges. Over the last year health officials and experts who tried to follow the evidence and protect the public's health, including implementing masking, contact tracing, and business restrictions, have faced harassment and political pressure and have at times been stripped of or resigned their positions. In addition, risk communication has been severely challenging in the face of high-level denial of the severity of the pandemic and overt politicization of public health measures intended to keep people safe. These failings have allowed the virus to flourish.

Historically, our public health agencies have not been sufficiently resourced to respond to a crisis of this magnitude. As just one example, during this response only $200 million was provided to States to support distribution and administration of vaccines during the largest max vaccination campaign in our Nation's history.

Support for our health care response has been similarly dismal. States often had to go it alone when procuring important things like ventilators, testing supplies, and PPE for front-line health workers.

Finally, the withdrawal from the WHO and withholding of contributions from COVAX both weakened our position as a global health security leader and limited global vaccination efforts.

With the new administration and Congress in place I am hopeful that our response to the rest of the pandemic will be much more evidence-based, coordinated, and effective. The American Rescue Plan currently being considered by Congress would provide significant support for the response, as well as authorization for new programs that will begin our investment in future preparedness. I look forward to the passage of this bill and better days ahead.

This concludes my testimony. I am grateful to the committee for inviting me and would be happy to take questions.

Thank you.

[The prepared statement of Ms. Watson follows:]

PREPARED STATEMENT OF CRYSTAL R. WATSON

FEBRUARY 24, 2021

Chairman Thompson, Ranking Member Katko, and Members of the committee, thank you for the opportunity to speak with you today about the COVID–19 pandemic.

My name is Crystal Watson. I am a senior scholar at the Johns Hopkins Center for Health Security and an assistant professor in the Johns Hopkins Bloomberg School of Public Health. The opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University. Today, I will provide comments on the status of the COVID–19 pandemic and the U.S. Government's re-

sponse efforts to date, as well as the major successes and failures of the last year, and what we should look forward to, and prepare for in the coming weeks and months.

THE COVID–19 PANDEMIC: A RETROSPECTIVE

One year ago, the director of our Center, Dr. Tom Inglesby, testified to this committee about the grave threat of COVID–19 and the need for a robust Federal, State, and local response. Dr. Inglesby's warning about the need for resources and coordination was made amidst significant uncertainty about how the pandemic would play out. At that time, there were only 100 recognized cases of COVID–19 and 6 deaths reported here in the United States. We did not know how severe the pandemic would be, what mitigation measures would be most effective at reducing transmission, whether we would be able to develop vaccines in time to prevent illness and save lives, and whether masks would be a significant and socially accepted means of limiting transmission, among other unknowns. What we did have at the time was a strong sense that the COVID–19 pandemic could be a once in a generation event, and that great attention and effort would be needed to prevent the worst-case outcomes.

One year later, thanks to the efforts of scientific and public health leaders, we have answers to many of the open questions of early 2020 and are beginning to vaccinate Americans in large numbers. Significantly though, we also have evidence that our National response did not meet its potential and that many thousands of unnecessary deaths have occurred as a result.

As of February 21, 2021, the world has now surpassed 111 million reported cases and 2.4 million reported deaths. In the United States alone, we have just reached a terrible cumulative total of half a million deaths Nation-wide and about 30 million cases.[1] More Americans have now died from COVID–19 than in WWI, WWII, Vietnam, Korea, and Gulf wars combined.[2]

For the last year, the United States has held the dubious distinction of leading the world in COVID–19 cases. Despite having only 4 percent of the world's population, our country has contributed 25 percent of the total number of reported cases and 21 percent of reported deaths.[3] We are also 8th in the world in terms of deaths per 100,000 population despite having significant success in improved treatment for COVID–19 patients. For those who might suggest that our case numbers are merely a result of more robust testing and surveillance capacity, it should be noted as an example that our Canadian neighbors, who are doing excellent surveillance, have 1/3 as many deaths, with only 58 per 100,000 population compared to our 152 per 100,000.[4]

And these are just the officially reported statistics. The true burden of COVID–19 is unknown but is estimated to be much higher than what is recorded. For example, the U.S. Centers for Disease Control and Prevention (CDC) estimates that there are actually between 4 and 5.4 times as many infections than what we have recognized.[5]

BEYOND THE NUMBERS

All of these numbers are so large that they are difficult to comprehend. The real toll of this last year cannot be captured in the facts and figures alone. Many of those lost to the pandemic had family, loved ones, friends, and coworkers whose lives have been irreparably altered by their passing.

There are many also who live with the aftereffects of this disease even if their symptoms were initially mild. Recent findings in JAMA show that on the order of 30 percent of people may have "post-COVID syndrome" with persistent symptoms such as fatigue, loss of taste and smell, memory problems, shortness of breath, and

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[1] Johns Hopkins Coronavirus Resource Center. *https://coronavirus.jhu.edu/map.html*.

[2] Hedges C. What every person should know about war. *The New York Times.* July 6, 2003. *https://www.nytimes.com/2003/07/06/books/chapters/what-every-person-should-know-about-war.html#:?:text=In%20the%20twentieth%20century%2C%20approximately,148%20in%20the%20Gulf%20War.*

[3] Andrew S. The U.S. has 4 percent of the world's population but 25 percent of its coronavirus cases. June 30, 2020. *https://www.cnn.com/2020/06/30/health/us-coronavirus-toll-in-numbers-june-trnd/index.html*.

[4] Johns Hopkins Coronavirus Resource Center. Mortality Analysis. *https://coronavirus.jhu.edu/data/mortality*.

[5] U.S. Centers for Disease Control and Prevention. Estimated Disease Burden of COVID–19. Updated January 19, 2021. *https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html.*

chest pain, which affect the ability to perform everyday activities like household chores or exercise.[6]

Many of us have experienced loss during this last year. Every death witnessed by a health care worker has taken a toll. People have lost their jobs, livelihoods, been evicted, suffered from isolation and loneliness, and faced extreme burnout from the prolonged intensity of this crisis.

Children have lost a year of in-person school and connection with peers, and families with young children are facing incredible pressures without adequate child care.

The consequences of COVID–19 have been appallingly inequitable. People of color and indigenous people have been disproportionately affected by this virus. When adjusted for age, Black, Pacific Islander, Latino/x, and Indigenous people have all been over twice as likely to die from COVID–19 than White people.[7]

The reason for this inequity is multifaceted, but we know that it stems from deeply-rooted problems that long pre-dated the COVID–19 pandemic. First, there are imbedded and long-established disparities in access to health care, so getting quality treatment is a challenge. We also know that a history of abuses has resulted in loss of trust in Government and the health care system, which translates to lower care-seeking behavior and vaccine acceptance among these populations. Furthermore, underlying health problems including diabetes and heart disease, which are more prevalent in minority populations because of systemic inequities and racism, also increase the risk for severe disease and death from COVID–19.

WHERE WE ARE RIGHT NOW IN THE UNITED STATES

While the last year has been a nightmare, in the past few weeks there are now glimmers of hope. The number of U.S. cases, hospitalizations, and deaths are all dropping rapidly from the winter peak, which was the highest of the pandemic. Daily case numbers have fallen from a high of over 295,000 reported on January 8 to about 72,000 as of February 20. Similarly, hospitalizations have come down dramatically from a National 7-day average of about 130,000 to about 63,000; and deaths are following, having dropped from a 7-day average of over 3,500 per day to around 2,000 per day. This is still far too many deaths, but the trend is in the right direction.[8] Ideally, we will need to reduce daily incidence of COVID–19 to under 10 cases per day per 100,000 population to truly get back to a place where we can effectively contact trace and manage individual cases. If we can do that, we will continue to drive infections down and hopefully prevent future surges.

I hope and expect that we will continue to see cases decrease to a much lower and more manageable level due to a combination of personal and public health mitigation measures like masking, social distancing, business restrictions, and contact tracing; and an increase in population immunity from vaccination and prior COVID infections. As of February 21, about 12.9 percent of the U.S. population has been vaccinated,[9] and more people in the United States have now received at least one dose of vaccine than the number of people reported to have had COVID.[10]

This is great news, and while the vaccine rollout has been far from easy or smooth, it continues to improve. I expect that vaccination rates will continue to increase as manufacturers deliver supplies and other vaccines become available for use in the near future.

My optimism here is somewhat tempered by the emergence of SARS–CoV–2 variants of concern. For example, the B.1.1.7 variant that has been shown to be more transmissible, and the B.1.351 and P.1 variants that have been shown to have some level of immune escape rendering vaccination and natural immune defenses less protective. Currently, the variant of most immediate concern in the United States is B.1.1.7 because our surveillance shows that it is already in at least 42 States and is outcompeting other variants, but it is still unclear whether this will result in yet another surge in U.S. cases. In the United Kingdom, B.1.1.7 necessitated National stay-at-home orders because of the steep increase of cases. But the United Kingdom surge also coincided with the winter holidays and occurred before

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[6] Gupta S. Almost a third of people with 'mild' COVID–19 still battle symptoms months later, study finds. *CNN Health.* February 19, 2021. *https://www.cnn.com/2021/02/19/health/post-covid-syndrome-long-haulers-gupta-wellness/index.html.*

[7] APM Research Lab. COVID–19 Deaths by Race and Ethnicity in the U.S. February 4, 2021. *https://www.apmresearchlab.org/covid/deaths-by-race.*

[8] The COVID Tracking Project. The Data. *https://covidtracking.com/data#summary-charts.* Accessed February 21, 2021.

[9] Huang P, Carlsen A. How is the COVID–19 vaccination campaign going in your state? *NPR Shots.* February 21, 2021. *https://www.npr.org/sections/health-shots/2021/01/28/960901166/how-is-the-covid-19-vaccination-campaign-going-in-your-state.*

[10] U.S. Centers for Disease Control and Prevention. COVID Data Tracker. *https://covid.cdc.gov/covid-data-tracker/#vaccinations.* Accessed February 21, 2021.

mass vaccination had started in earnest, which was the worst possible timing. I am tentatively hopeful that vaccination and current limitations on business occupancy and travel will prevent a similar resurgence in the United States. However, it is something we must watch closely.

Variants with mutations that escape our immune defenses like P.1. and B.1.351 may yet become a greater threat, particularly in the fall and winter of 2021. If we are to avoid a resurgence of cases at that time, we need to make sure that our vaccines are as protective as possible, which may require a third dose or vaccine booster. Vaccine manufacturers, scientists, and Government officials are currently working hard to plan for this possibility, but it is a significant scientific and logistical challenge that remains for the country.

CURRENT GLOBAL PICTURE

I am focusing largely on the U.S. response in today's testimony but would be remiss if I didn't at least touch on the global status of the pandemic and vaccine rollout.

There are a handful of countries that have been so successful at keeping the SARS–CoV–2 virus out and quenching any introductions before they can turn into epidemics, that they are virtually virus-free. In these parts of the world, citizens are able to live largely apart from the pandemic and go about their normal lives. There are also countries with virtually zero capacity to respond to COVID–19, and in those places, we do not have enough disease surveillance to know how people are affected.

Vaccination has been the center piece of the response in the United States and other high-income countries since December, while low- and middle-income countries still wait for vaccine. The international leader in vaccination thus far is Israel, which has over 30 percent of its population fully vaccinated. The good news from Israel is that preliminary data seems to show that vaccination there has provided both significant protection from infection and from severe disease and death, even in the face of the B.1.1.7 variant as the dominant variant in the country.[11]

While this is heartening, the success of Israel is in sharp contrast to low-income countries that have not even begun vaccinating their health care workers, much less the general population, and will likely not have sufficient vaccine for many months to come. This global inequity is resulting in a humanitarian crisis for low- and middle-income countries, and it also represents a significant risk for the entire world; the longer this virus circulates at high levels, the greater the risk of new mutations that could result in dangerous variants which are resistant to vaccines and could prolong the pandemic.[12]

SUCCESSES OF THE U.S. PANDEMIC RESPONSE

Next, I would like to take a few moments to highlight some of the successes and failures of the U.S. response over the last year.

First, the successes. It is so important to recognize that the U.S. response represents collective work of tens of thousands of people across the country, as well as millions of Americans who had to sacrifice tremendously to take protective actions. People working collectively and non-stop over the past year in Federal agencies; State, territorial, Tribal, and local governments; hospitals and Dr. offices; mental health organizations; universities; laboratories; mortuaries, and many other organizations. It has been a year of constant and extreme stress, and life-and-death decisions. Many lives have been saved by the actions of our responders, and we should be truly thankful for the heroic efforts of those who have worked to reduce COVID–19's impact.

We also owe a great debt of gratitude to essential workers who have kept our society functioning, our supply chains moving, our shelves stocked, and our power running. People have shown great courage in the face of the virus and have maintained continuity of critical societal functions, allowing us to be more resilient than we might have imagined.

Finally, the biggest and most visible success of the past year is the development of multiple highly safe and effective COVID–19 vaccines in under a year. I cannot emphasize enough what a technical feat this is. The reasons for this success are

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[11] Mitnick J, Regalado A. A leaked report shows Pfizer's vaccine is conquering COVID–19 in its largest real-world test. *MIT Technology Review.* February 19, 2021. *https://www.technologyreview.com/2021/02/19/1019264/a-leaked-report-pfizers-vaccine-conquering-covid-19-in-its-largest-real-world-test/.*

[12] Shah S, Steinhauser G, Solomon F. Vaccine delays in developing nations risk prolonging pandemic. *The Wall Street Journal. https://www.wsj.com/articles/faltering-covid-19-vaccine-drive-in-developing-world-risks-prolonging-pandemic-11613557801.*

many, but it is anchored in planning, capabilities, and science that have been developed over time by the U.S. Government, international partners, industry, and academia. This experience should shape our medical countermeasures development planning and investment for the future. There are additional lessons and new technologies that we can harness to be ready for the next pandemic. The COVID–19 pandemic has taught us that we cannot simply plan for known viral threats and limit ourselves to a list-based approach to medical countermeasure development. The Department of Health and Human Services and the Department of Defense should also invest in pathogen-agnostic platform technologies with the goal of quickly developing new medical countermeasures against novel viruses.

FAILURES OF THE U.S. PANDEMIC RESPONSE

My time to testify here does not adequately allow for a full reckoning for the failures of the U.S. response over the last year, but there are some that I want to make sure to highlight for this committee.

Over the last year, public health leaders, scientists, and many others who have spoken out in defense of scientific fact and truth about the pandemic have suffered retribution and terrible treatment. Health officials and experts who have implemented or recommended evidence-based interventions including masking, contact tracing, and business restrictions, have been threatened both verbally and physically. They have been harassed on-line and had threatening packages mailed to their homes. They have faced political pressure and backlash from elected officials from the top of Government on down and have at times been stripped of or resigned their position in the midst of the pandemic. More than 27 health officers in 13 States have resigned or been fired in the last year, leaving our public health agencies even less equipped to respond. This is unacceptable and dangerous.[13]

As colleagues eloquently stated in a recent JAMA commentary, "Instead of attacking their health officials, elected leaders should provide them with protection from illegal harassment, assault, and violence."[13] They should also be turning to their health officers for public health advice and providing them with the resources that will make their jobs more successful.

This leads me into a second and related failing of this response: The politically-driven failure to heed expert advice, silencing or sidelining of Federal experts, and censoring or cherry-picking of data. As examples, the previous administration reportedly sought on several occasions to withhold important data from the public about the impending crisis. And, on multiple occasions in 2020, political appointees altered CDC's Morbidity and Mortality Weekly Report publications and other reports that did not align with the White House's messaging about pandemic risk or preferred courses of action.[14]

High-level denial of the severity of the pandemic and disempowerment of scientists and public health experts led both to under-resourcing of the response and significant confusion for the public. Furthermore, overt politicization of the public health measures intended to keep people safe allowed the virus to flourish as people were convinced that wearing a mask was weak, that public health officials were trying to steal their identities when conducting contact tracing, and that restrictions on businesses were scientifically unfounded. This is why we have so many more cases and deaths than other countries.

Within the response itself, there are a few significant issues that should be highlighted. Our public health agencies have been underfunded and overburdened long before COVID–19, through multiple Republican and Democratic administrations, but they were also not sufficiently resourced or supported by the Federal Government during this response. While funds from the Cares Act did go to health departments, it was not enough.

Support for State, territorial, and Tribal vaccination planning is a particularly damaging failure. While the U.S. Government has understandably spent billions of dollars on vaccine development, only $200 million was provided to States for the actual distribution and administration of vaccine in the largest mass vaccination effort that our country has ever undertaken. This is despite pleas from public health experts for additional funding and guidance.[15]

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[13] Mello M, Greene JA, Sharfstein JM. Attacks on public health officials during COVID–19. *JAMA.* August 5, 2020. *https://jamanetwork.com/journals/jama/fullarticle/2769291.*

[14] Viglione G. Four ways Trump has meddled in pandemic science—and why it matters. *Nature News.* November 3, 2020. *https://www.nature.com/articles/d41586-020-03035-4.*

[15] Florko N. Trump officials actively lobbied to deny States money for vaccine rollout last fall. *Stat News.* January 31, 2021. *https://www.statnews.com/2021/01/31/trump-officials-lobbied-to-deny-states-money-for-vaccine-rollout/.*

Support for our health care response has been similarly dismal. States often had to 'go it alone' in ensuring supply chains for important things like ventilators, testing supplies, and personal protective equipment for front-line health workers.

Last, but certainly not least, the United States' withdrawal from the World Health Organization and the withholding of contributions to COVAX both weakened our position as a global health security leader and limited burgeoning global vaccination efforts. I am encouraged to see that the United Stated has reversed these positions and has pledged significant support to COVAX.

NEW ADMINISTRATION PRIORITIES AND CONTINUED PROGRESS

With the new Biden administration and this Congress in place, I am hopeful that our response to the remainder of the COVID–19 pandemic will be much more evidence-based, coordinated, and effective.

Recent decisions to support acquisition of additional vaccine and enable health and scientific experts to communicate directly and honestly with the American people are already paying dividends.

The administration should continue to prioritize strong leadership for the response in Federal agencies, including by appointing an Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services as soon as possible; ensuring that sufficient Federal support and resources are being provided to enable equitable access to vaccine; and making every investment necessary to prepare for the possibility of updating vaccines to protect against immune escape variants.

Finally, I am glad to see that the American Rescue Plan legislation currently being considered by Congress provides significant support for the on-going response as well as funding and authorization for new programs that will begin our investment in our future preparedness. I look forward to the passage of this bill and better days ahead.

That concludes my testimony. I am grateful to the committee for inviting me to contribute to the hearing and would be happy to take any questions.

Chairman THOMPSON. Thank you. Thank you very much.

I now ask Dr. Ezike to summarize her statement for 5 minutes. I apologize if I mispronounced the word. Charge it to my hearing, not my heart.

STATEMENT OF NGOZI O. EZIKE, MD, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Dr. EZIKE. No problem, sir. Thank you. Chairman Thompson, Ranking Member Katko, and distinguished Members of the committee, thank you for inviting me here to speak today about Illinois' response to the coronavirus pandemic.

We have had more than 1.1 million cases of COVID–19 in Illinois and, even more deplorable, over 20,000 parents, grandparents, and children who have succumbed to this baleful disease. From the outset of the pandemic our response has been guided by a focus on data, science, and equity. 2020 mitigations necessary to curb infection transmission and protect health care capacity still left an indelible mark on the State of Illinois and the lives of our residents.

As a State we have made significant investments in testing and contact tracing. Our State lab was the first in the country to validate and run in-house the CDC's PCR test and we are proud to rank fifth among States for a total number of COVID tests run.

As vaccines are distributed, the benefit of vaccination will depend on: (1) How rapidly and broadly we can turn vaccine into vaccination and (2) how effectively we limit viral replication, thus limiting the creation of new variants of concern. In Illinois more than 2.3 million doses have been administered. Currently we have administered 90 percent of all delivered doses outside of the long-term care

pharmacy partnership program. We currently rank fifth among States in total vaccines administered.

The Department of Public Health has been intentional about engaging disproportionately-impacted communities. From the beginning of our response, we created a health equity work group that was embedded into all aspects of the response. We assembled a diverse speakers bureau to support multilingual virtual town halls for cultural groups, work groups, faith communities, and other special groups. Our Ambassador program enlists nearly 1,000 Illinois residents to share information via personal social medial channels to their friends and family and peers on prevention, testing locations, treatments, and vaccines. We aim to create confidence and trust in the available vaccines through education and culturally appropriate respectful engagement. Our hope is that when people get the facts, then they will get the vax.

When I testified before this committee a year ago, one of our primary concerns was a lack of PPE for health care workers and first responders. Today, we are in a much better position as production and demand have equalized. Even so, we learned a very valuable lesson about the global supply of medical products that must inform our future planning for Strategic National Stockpile and domestic production.

One of the biggest hurdles to a successful response over the past year has been a lack of clear and consistent communication and modeled messaging from the highest levels of government on down. While we appreciate the increased planning, transparency, invocation of the Defense Production Act for vaccine supplies and PPE and the securing of 600 million doses by July, today we still have to contend with the good trouble of having more rolled-up sleeves than vaccine-filled syringes.

We are seeing increases in our vaccine supply and welcoming the strong commitment from the Federal Government to augment the States' vaccination efforts. The promise of a 3-week lead time on vaccine allocation has been welcome news both to the States and to all of our local partners. Last month Governor Pritzker announced the activation of the Illinois National Guard to assist local health departments in administering vaccines. To date, 44 teams have been deployed with the plan to reach 100 total Guard teams in the coming weeks.

FEMA is another great partner in our efforts and the 100 percent Federal cost coverage allows us to support additional high-priority areas. We have also discussed mass vaccination centers and are hopeful that this Federal-State partnership will come to fruition.

To bring this pandemic to an end we need to stay focused on the multi-layered approach of masking, social distancing, testing, genomic sequencing, contact tracing, in addition to vaccination. To maintain all these efforts States need consistent resources, but also expertise and National guidance. Yes, National strategies have a clear role and function in battling pandemic because State borders do not keep out the virus. Yes, our National strategy has to include control of the virus in other countries, especially developing countries, because as we have also learned, no one is truly safe until

all of us are safe and viruses are only as far as away as the furthest flight or the furthest cruise voyage.

I look forward to continued collaboration with Congress and the administration to see the other side of this pandemic, where pandemic fatigue, frustration, and fear is replaced with the post-pandemic side of relief.

Thank you.

[The prepared statement of Dr. Ezike follows:]

PREPARED STATEMENT OF NGOZI O. EZIKE

FEBRUARY 24, 2021

Chairman Thompson, Ranking Member Katko, and distinguished Members of the committee, thank you for inviting me here today to speak about Illinois' response to the coronavirus pandemic. Over the past year in Illinois, we have had more than 1.1 million cases of COVID–19 and, unfortunately, more than 20,000 of our people have succumbed to this baleful disease.

From the outset of the pandemic, our response has been guided by a focus on data, science, and equity. The year 2020 was marked by mitigations necessary to curb infection transmission and protect health care capacity, but they also left an indelible mark on the State of Illinois and the lives of our residents.

As a State we have made huge investments in testing and contact tracing and are proud to rank 5th among States and territories for the number of COVID tests administered. Illinois was the first State in the country to validate the Centers for Disease Control and Prevention's (CDC) COVID–19 PCR test and all 3 of our State laboratories began running samples early in the pandemic. These 3 laboratories began State-wide sentinel surveillance testing almost a year ago, enabling Illinois to determine how COVID–19 was circulating in our communities.

So, it is with great hope that we embrace the advent of vaccines that are a pathway to ending this calamitous period in our State and National history. Through efficient and effective distribution of the vaccine, we can suppress the spread of the virus and save many lives. The Illinois Department of Public Health (IDPH) has been working in close partnership with our 97 local health departments, hospitals, retail pharmacies, Federally-qualified health centers (FQHCs), and many other partners across the State to ensure vaccination occurs with both velocity and equity. To date we have enrolled hundreds of new providers to receive and administer COVID vaccines. We have also expanded scopes of practice to allow more health care providers to administer vaccines, such as dentists, pharmacists, and EMTs above the basic level.

In Illinois, vaccines are currently distributed according to the population of each county, adjusted to ensure health equity using the COVID–19 Community Vulnerability Index (CCVI), a measure of vulnerability to COVID–19 at the State, county, or census tract level that combines health determinants such as epidemiology of underlying chronic conditions and access to care with the CDC Social Vulnerability Index.[1] Due to the initial limited supply of vaccine and the established priority groups, we directed our allocations of vaccine to local health departments (with subsequent distribution to hospitals) and our large retail pharmacy partners. As vaccine availability continues to increase, we will allocate across a growing, more expansive provider network throughout the State.

The ultimate benefits of vaccination against COVID–19 will depend on how well we are controlling the spread of the virus and how swiftly and broadly we can implement the vaccine.[2] In Illinois, 1,779,143 people have received their first dose of vaccine as of February 21, 2021.[3] We are doing everything we can to vaccinate our

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[1] Surgo Ventures. (2020, December). *COVID–19 Community Vulnerability Index (CCVI) methodology. https://covid-static-assets.s3.amazonaws.com/US-CCVI/COVID-19+Community+Vulnerability+Index+(CCVI)+Methodology.pdf*.

[2] Paltiel, A.D., Schwartz, J.L., Zheng, A., & Walensky, R.P. (2020). Clinical outcomes of a COVID–19 vaccine: Implementation over efficacy. *Health Affairs,* 40(1). *https://doi.org/10.1377/hlthaff.2020.02054*.

[3] Centers for Disease Control and Prevention. (2021, January 31). Number of people receiving 1 or more doses reported to the CDC by State/territory and for selected Federal entities per 100,000 [Data set]. Retrieved from *https://covid.cdc.gov/covid-data-tracker/#vaccinations*.

share of the more than 200 million people necessary to achieve herd immunity against COVID–19.[4]

In order to reach populations that have been disproportionately impacted by COVID, IDPH has been intentional about engaging hard-hit communities across the State with the most up-to-date information, answering questions and addressing any concerns people may have, particularly around vaccine hesitancy and distrust. False narratives abound—especially in our communities of color—and we must come together to create confidence and trust in the available vaccines. To this end we created a COVID–19 Ambassador program to support State efforts to stop the spread of COVID–19 by enlisting individuals to promote and share information among their friends, family, peers, and neighbors on prevention measures, testing resources, vaccines and other relevant information.

While we await additional vaccine supply and the approval of new vaccines by the Food and Drug Administration (FDA), we must continue the public health measures that will control the spread of the virus: Masking, testing, and social distancing. A multi-pronged approach supported by the Federal Government that includes the following could improve the effectiveness of nonpharmaceutical interventions in Illinois and across the country:

- An aggressive expansion of genomic sequencing infrastructure to assess the threat of new variants, including the ability to analyze higher numbers of COVID–19 samples and easily transfer data between the CDC, State-run labs, and public health practitioners to inform mitigation efforts.
- Continuation of paid sick leave as required by the now-expired Families First Coronavirus Response Act (FFCRA), which one study found led to more than 400 fewer reported cases of COVID–19 per State per day compared to the pre-FFCRA period and to States that had already enacted paid sick leave.[5]
- Support for wide-spread molecular testing and isolation,[6] especially for high-priority populations, and rapid point-of-care testing in high-priority settings, including schools and workplaces.
- Additional direct payments to individuals to encourage compliance with public health guidance for quarantine, isolation, and stay-at-home orders,[7] especially in economically marginalized communities.[8]
- Distribution of masks, preferably medical-grade,[9] to every person to enable universal masking.[10]
- Grants to improve indoor air ventilation [11] in high-priority settings, including schools and long-term care facilities.
- Promulgation of National standards and practices for contact tracing, especially for data collection.
- Workforce expansion strategies for vaccinators and other public health personnel, including deployment of Federal personnel to Illinois as a force multiplier to our already substantial but inadequate immunization resources.

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[4] Randolph, H.E., & Barreiro, L.B. (2020). Herd immunity: Understanding COVID–19. *Immunity,* 52(5), 737–741. *https://dx.doi.org/10.1016/j.immuni.2020.04.012*.

[5] Pichler, S., Wen, K., & Ziebarth, N.R. (2020). COVID–19 emergency sick leave has helped flatten the curve in the United States. *Health Affairs,* 39(12). *https://doi.org/10.1377/hlthaff.2020.00863*

[6] Rannan-Eliya, R.P., Wijemunige, N., Gunawardana, J.R.N.A., Amarasinghe, S.N., Sivagnanam, I., Fonseka, S., Kapuge, Y., & Sigera, C.P. (2020). Increased intensity of PCR testing reduced COVID–19 transmission within countries during the first pandemic wave. *Health Affairs,* 40(1). *https://doi.org/10.1377/hlthaff.2020.01409*.

[7] Wright, A.L., Sonin, K., Driscoll, J., & Wilson, J. (2020). Poverty and economic dislocation reduce compliance with COVID–19 shelter-in-place protocols. Journal of Economic Behavior & Organization, 180, 544–554. *https://dx.doi.org/10.1016/j.jebo.2020.10.008*.

[8] Chang, S., Pierson, E., Koh, P.W., Gerardin, J., Redbird, B., Grusky, D., & Leskovec, J. (2020). Mobility network models of COVID–19 explain inequities and inform reopening. *Nature,* 589, 82–87. *https://doi.org/10.1038/s41586-020-2923-3*.

[9] Tufekci, Z., & Howard, J. (2021, January 13). Why aren't we wearing better masks? *The Atlantic. https://www.theatlantic.com/health/archive/2021/01/why-arent-we-wearing-better-masks/617656/*.

[10] Howard, J., Huang, A., Li, Z., Tufekci, Z., Zdimal, V., van der Westhuizen, H., von Delft, A., Price, A., Fridman, L., Tang, L., Tang, V., Watson, G.L., Bax, C.E., Shaikh, R., Questier, F., Hernandez, D., Chu, L.F., Ramirez, C.M., & Rimoin, A.W. (2021). An evidence review of face masks against COVID–19. *Proceedings of the National Academy of Sciences of the United States of America, 118(4). https://doi.org/10.1073/pnas.2014564118*.

[11] Noorimotlagh, Z., Jaafarzadeh, N., Martinez, S.S., & Mirzaee, S.A. (2020). A systematic review of possible airborne transmission of the COVID–19 virus (SARS–CoV–2) in the indoor air environment. *Environmental Research,* 193, 110612. *https://doi.org/10.1016/j.envres.2020.110612*.

- Intentional community engagement and education strategies to promote vaccine science as a preventive method to thwart vaccine misinformation and distrust for any future campaigns.

Much has transpired over the past year; we have endured unthinkable loss and mounted a forceful response to contain the spread of this disease, save lives and rollout a massive effort to vaccinate our population.

One of the biggest hurdles to a successful response over the past year has been a lack of communication and muddled messaging from the highest levels of government. Though it is still early, the Biden administration has already demonstrated a strong desire to better engage the States and this is a major improvement from where we were a year ago. In concert with improved communication, we are seeing increases within our vaccine supply chain and commitment from the Federal Government to augment what States have already implemented. The promise of a 3-week lead time on vaccine allocation projections has been welcome news to States and our partners on the ground. In Illinois, as may be the case in other States, addressing the large number of second doses due to the public and its impact on available first doses has been challenging. An informative and transparent discussion on vaccine allocation to the States on the part of the Federal Government could go a long way to helping States like Illinois address the angst felt by local governments who receive small quantities of doses.

While we appreciate the increased planning and transparency, this has not eliminated the need for additional vaccine supply. In testimony I made a few weeks ago to the House Energy and Commerce Committee, I urged the Federal Government to leverage all resources and powers at their disposal to ramp up the manufacturing and purchase of additional vaccine and associated supplies. I applaud news that the Biden administration has invoked the Defense Production Act to increase production of vaccines, at-home coronavirus tests and additional personal protective equipment (PPE); as we know, the advent of vaccines does not eliminate the need for PPE or testing. With production increases and the pending approval of an additional vaccine on the market, we are hoping to see significant increases to vaccine allocations in the next few weeks. Our local health departments, FQHCs, hospitals and other partners are standing ready to ramp up exponentially.

Looking back to where we were last year and the difficulty we faced in procuring PPE, I am grateful for how far we have come. When I testified before this committee a year ago, our largest concern was the lack of PPE for health care workers and for our residents. I discussed our challenges in supplying local health departments and hospitals with required PPE and the State's extraordinary efforts to source common products like masks and gloves. Today we are in a much better position as production and demand have equalized. Even so we learned a valuable lesson about the global supply of medical products that must inform our future planning for strategic stockpiles and domestic production. We trust the Federal Government is acknowledging that lived experience and look forward to discussions with you to harden our systems against future crises.

Being a National leader in COVID–19 testing comes with a commitment to maintaining and increasing testing levels. Illinois began its COVID–19 testing mission in its 3 State laboratories with very small supplies of reagents, viral transport media (VTM) and consumables required to run tests. Further, a year ago we did not have a comprehensive network of public laboratories capable of rapidly scaling to meet a demand such as COVID–19. Like today's vaccine crunch, IDPH with assistance from the Federal Government went about resourcing needed supplies to not only maintain but increase by orders of magnitude the availability of testing. Not leaving our fate in the hands of others, IDPH developed its own recipes for VTM and reagents. We optimized our PCR processes to reduce time and resource consumption. Automation and high-throughput equipment allowed the State health department labs to go from processing hundreds to thousands of samples per day.

Going forward Illinois acknowledges the need for a robust and enduring public health lab infrastructure, we ask the Federal Government to join with us in building increased education opportunities for people interested in becoming laboratorians and researchers. This must be accomplished by investing in public universities and colleges, both for increasing degrees as well as by providing laboratory infrastructure that serves as a training platform in good times and back up lab capacity in troubled times.

Public health infrastructure was again critical as Illinois approached vaccine delivery. Long before COVID–19, IDPH along with Federal and local partners developed medical countermeasure plans for mass vaccination in Illinois. Even so, in September 2020, IDPH organized its COVID–19 vaccination plan with an understanding that unlike other crises, this potential antidote would come in small quantities to start and with significant handling challenges. A different approach involv-

ing local and National providers, focused on equity and compassion for those people most ravaged by this disease would be required.

Notwithstanding our planning, Illinois has experienced the same difficulties as other States. Vaccination efforts in Illinois were hampered by conflicting Federal messaging a lack of consistent information on vaccine deliveries. Operation Warp Speed's many unmet promises left Illinois holding the bag as our people sought reliable answers to when they could expect to be vaccinated. Reduced or postponed allocations and outright cancellations left Illinois receiving far fewer doses than advertised. We have taken great satisfaction in the improvements made in both communication and actual doses delivered since late January and stretch forth our hands in anticipation of even higher allocations of vaccine to shortly come.

We have distributed vaccine with equity garnishing our every thought. We have also focused on speed, partnering with those who could vaccinate the population the fastest, while working with others to improve their delivery of services, such as the activation of the National Guard to increase capacity and support local operations across the State. Illinois is ready for more vaccine and we will not delay in its use.

On January 25, 2021, the State moved into Phase 1B of our vaccine rollout.[4] Initial advice from the CDC Advisory Committee on Immunization Practices (ACIP) targeted front-line workers and adults aged 75 years and older for Phase 1B.[12] In keeping with our commitment to equity and understanding the disparities in life expectancy, generally, and age at death from COVID–19 in Illinois specifically,[5] IDPH chose to expand our priority populations for 1B to include adults aged 65 years and older. In doing so, Illinois sought to save lives in a truly equitable manner, recognizing that longstanding inequities, as well as institutional racism has reduced access to care, caused higher rates of environmental and social risk, and increased comorbidities for people of color. After taking into account the expectation of increased vaccine supply in the coming weeks, Governor JB Pritzker announced that on February 25 the State will expand Phase 1B eligibility to include people aged 16 to 64 years with co-morbidities and underlying conditions associated with increased risk for more severe COVID–19 as defined by the CDC,[13] along with individuals with disabilities.

In late January, Governor Pritzker also announced the activation of the Illinois National Guard to assist local health departments in administering vaccinations; a move that was made possible by the Biden administration approving 100 percent Federal coverage of the cost. To date 44 teams have been deployed across the State and over the course of February more than 50 total National Guard teams will be deployed to expand access to vaccines in high-need areas across the State, in concert with clinics hosted by local health departments, hospitals, and pharmacies. The Federal Emergency Management Agency (FEMA) has been a great partner in our efforts and the increase to 100 percent (up from 75 percent initially) Federal cost coverage of these sites has allowed us to support more high-priority areas in the State than we initially expected.

Finally, in order to expeditiously administer vaccinations I have urged the Federal Government to assist State efforts by partnering with us to establish Federally-run mass vaccination centers. Since then, we have discussed the idea of such mass vaccination centers in Illinois with the Federal Government and are hopeful that this Federal/State partnership will come to fruition.

In order to bring this pandemic to an end, States need continued, consistent support and resources from the Federal Government. New, highly-contagious variants are threatening our progress and we need our Federal partners to align their efforts with ours to help solve practical, operational issues; thankfully we seem to be moving in this direction.

Thank you for the opportunity to share Illinois' experience over this past year. We will continue to let data, science, and equity guide our approach and I look forward to working with Congress and the administration to see the other side of this pandemic.

Chairman THOMPSON. Thank you very much.

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[12] Dooling, K., Marin, M., Wallace, M., McClung, N., Chamberland, M., Lee, G.M., Talbot, H.K., Romero, J.R., Bell, B.P., & Oliver, S.E. (2020, December 22). The Advisory Committee on Immunization Practices' updated interim recommendation for allocation of COVID–19 vaccine—United States, December 2020. *Morbidity and Mortality Weekly Report,* 69(5152), 1657–1660. *http://dx.doi.org/10.15585/mmwr.mm695152e2*.

[13] Centers for Disease Control and Prevention. (2021, February 3). People with certain medical conditions. *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html*.

I now ask Mr. McMahon to summarize his statement for 5 minutes.

STATEMENT OF J. RYAN MC MAHON, II, COUNTY EXECUTIVE, ONONDAGA COUNTY, NEW YORK

Mr. MCMAHON. Thank you. Chairman Thompson, Ranking Member Katko, Members of the committee, it is an honor and a privilege to be here today to tell the story from the local government perspective. Our story isn't unique to our community, but to local governments throughout this pandemic. The reality is it is important when we tell this story that people understand what we do.

Our county government does different things in each State. That has been part of the challenge in the global pandemic at the local level. In our county in New York State—and I know there are Members from New York State on this panel as well that know this—in New York City—New York City is actually a county as well—in New York State, the rest of the counties, we take care of our community's most vulnerable. We have the children and family service departments to watch our children, we have the adult long-term care departments to take care of our elderly, we have our economic security departments to take care of our poor, and we have our local health departments that help deal with health equity and public health, day in and day out. During a pandemic everybody is vulnerable. We were the local government on the front lines of this. When we look at what we do and what we had to do, reliving the last year and our responses, is actually a traumatizing experience if we think about all we have been through together collectively in this country.

We went from planning, when we learned of this virus, to preparing to having to do mitigation at the local level, canceling community gatherings, canceling parades, before we even had a case. Then we went to response to a pandemic at the local level. In our community—we are in central New York—our—in New York City, in Long Island, and the Hudson Valley was ground zero for this pandemic. We had a 2-week head start to implement mitigation, implement our plans, and prepare for a response.

What is response? We got very familiar very quickly with terms like contact tracing, testing for a virus, competing for tests throughout the committee, quarantine. These are all things that we never thought we would have to do at this point in time. We then went into a situation where we are focused in on shutdowns to help mitigate the spread of the virus throughout the State. We then we through a restart process where we started to reopen our economy, where our government were now responsible for regulating social distancing, physical distancing, capacity amongst businesses, things we never thought we would be.

As we restart the economies, the Operation Warp Speed and the vaccination came to fruition. We are now in the process of vaccinating, developing distributing, underutilized infrastructure, how do we get to specific communities within our community that are underserved intentionally. That is something that we have focused on in Onondaga County. We will be the front line leaders in recovery as well.

One thing I do really want to highlight is that once we are done vaccinating, and we will at some point, this emergency is not over whatsoever. The reality is the victims of this pandemic are far more than just those who become COVID-positive. We have had 31,000 COVID-positive residents in my county, we have had over 650 people in my county die, but it is becoming clearer and clearer every day the crisis of mental health, opioid overdoses, where we have seen increases between 40 to potentially 70 percent in our county. What we are seeing what is happening to our children as hybrid learning schedules are not meeting the needs of our children for school.

But this is the macro level. What are some of the unique experiences that we had that I think bring value to you as you form policy. In the beginning we were not prepared for PPE. We were scrambling for test kits. Every night we were looking for test kits throughout our community to get people just tested for this virus on March 16 when the virus came to our community. We were scrambling for masks, for gowns, for gloves with all of our partners. We were competing not only against other local governments and hospitals, but States and the Federal Government as well. It is abundantly clear that there needs to be a supply chain repatriotization to our country to address this moving forward.

We communicated daily at the local level, as other did at the Federal level and State level. That helped provide comfort and calm to our community, but we had new challenges. Everyone was vulnerable. We had to implement continuity of food operations, we had to implement continuity of care operations for our essential workers where they had free day care. Things that were never in the traditional response to an emergency, but now local governments were fronting these costs to make sure that we had nurses going into hospitals, to make sure that we had other essential workers going on so society moved on.

We did this all at a point where we were the largest community in the country to receive no direct CARES Act support. CARES Act funding flowed through the States. There was money earmarked for local governments. Not all States passed that money onto the local governments. This led to a huge economic challenge for us in Onondaga County, a community of 462,000 people that would have normally received $80+ million if we had over half a million people. We received no direct CARES Act funding for response because of the way the emergency aid flowed.

We quickly utilized and worked with our partners at up-State hospitals, Syracuse University, to implement great testing strategies. We implemented these testing strategies to help restart both Pre-K through 12 education, but also higher education. We continue to asymptomatically test in our schools and the positive rates are phenomenal because of this. We took the strategy that we should not be embarrassed to identify the virus anywhere because the only way we get our arms around this virus and end this pandemic is to identify it everywhere. We test and we test and we test today. Because of that our positive rate in our community today, after a surge from Halloween through Christmas, is at 1 percent for a 7-day average. Our active caseload on January 3 was 6,000 cases, today it is 660 cases.

We are now in the process of vaccinating and vaccinating is something that counties do. The Federal Government funds us to actually put together mass vaccination plans. We put together these plans, we are ready for this process. To date we feel we have been underutilized. The supply we know is an issue and we know it is getting better. But specifically, to intentionally get to the hard-to-reach communities, our new American communities, our minority communities, nobody is better served to do that than county governments. We have the human service partners. These are our clients day in and day out. We can get the job done. We need to be brought into the game in a larger aspect.

Thank you, Mr. Chairman. I am prepared to take questions when appropriate.

[The prepared statement of Mr. McMahon follows:]

PREPARED STATEMENT OF J. RYAN MCMAHON, II

Good morning Chairman Thompson, Ranking Member Katko, and the rest of the House Homeland Security Committee. Thank you for the opportunity to address you today regarding our community's efforts to confront the Coronavirus pandemic and the perspective gained 1 year later.

Located nearly 250 miles from the epicenter of COVID–19 in New York State, Onondaga County had the benefit of understanding how COVID–19 affected our neighbors in the Hudson Valley and New York City before the virus reached our community. The devastation would be undeniable and we moved quickly to activate our plan to mitigate loss and keep people safe.

Our first confirmed case of COVID–19 in Onondaga County occurred on March 16, but our teams in Emergency Management and the Health Department had been preparing for months. As you probably know, it is the local governments who are on the front lines fighting any pandemic and COVID–19 is no different. With a State of Emergency already declared and an aggressive campaign under way encouraging people to practice physical distancing, we quickly moved to bring together all of our community partners including hospitals, local governments, epidemiologists, and others to ensure we could take decisive action as the data merited.

We partnered with a local Health Center and set up community testing. Just as important, we made efforts to ensure that our neighbors who lived in communities often hardest-hit by public health emergencies had easy access to the resources they needed to stay safe.

Schools also were shut down, but not before ensuring every district had a plan to take care of their most vulnerable. We know that for many children, school is the only place they receive at least 2 meals a day and we worked tirelessly to make sure those children continued to receive the meals they needed. We also partnered with Childcare Solutions to arrange for our first responders, essential employees, doctors, nurses, and nursing-home staff to have child care. If these folks could not get to work during a global health pandemic, then the entire system collapses.

Acquiring personal-protective equipment was—let's say—challenging. The PPE chain was the Wild, Wild West. Masks that you could get for under a dollar were now $8 or $9. People reached out to us who miraculously had contacts in Singapore, China, and Taiwan for a small advance of $500,000. Legitimate governments, however, do not make these deals. We pressed on, qualifying different supply chains, and finally bought PPE at decent prices. We even secured ventilators in the event we needed to transform the Manley Field House at Syracuse University into a hospital.

At the heart of our response to COVID–19 was our communication with the public. We held briefings twice a day, once via Facebook Live at noon and another briefing with the press at 3. These briefings were televised across northern and Central New York and we took the opportunity to emphasize that we are all in this together and it would take everyone doing their part to ensure our community emerges stronger than before. As New York State continued to shut things down and we asked people to modify their social behavior, I was heartened at the number of people tuning in, listening, and buying in to these sacrifices they were being asked to make, as scary as they were. We spoke about testing, quarantines, the number of cases, food security, day care, and mental-health programs; anything and everything that was relevant to the well-being of the public. Our job was to tell the truth without the slant of politics. We were asking people to sacrifice, and they had to know

why. I never Monday-morning quarter-backed the decisions at the Federal or State level. I just talked about how they impacted us, and I believe people appreciated our straight-forward approach.

Emotionally, the loss of life was overwhelming, but I knew the unintended consequences of these shut-downs would be severe. Whether it was individuals unable to identify or report domestic violence or child abuse to the rising cases in opioid overdoses or just the sheer devastation of our local economy, the human toll of this virus extended beyond what anyone could have imagined.

Over the last year, there has been a significant increase in the number of fatal opioid overdoses in Onondaga County. From January through September 2020 there was a 40 percent increase in opioid overdose deaths compared to the same time period in 2019 (121 deaths vs 86 deaths, respectively). The pandemic has exacerbated the opioid epidemic, through risk factors such as high unemployment rates, social isolation, and despair, as well as the disruption of available treatment and harm reduction support services that individuals with substance use may depend on.

We were shut down for months and lost millions of dollars in sales tax not to mention our room-occupancy tax essentially evaporated. We had to cut county government and execute rigorous austerity measures. Twice we offered retirement incentives, but still had to implement furloughs, voluntary and involuntary. We were facing a $70 to $80 million shortfall as we prepared our next budget. Adding salt to the wound, our population is 461,000, just shy of the half a million Federal requirement to receive direct Federal aid which would have totaled at least $100 million from CARES Act funding. The current funding formula resulted in the Federal Government sending our money to the State, but it was never redirected to us. This means that we have funded, and continue to fund, every aspect of this fight using whatever resources we could muster at the local level. Everything from testing, contact tracing, purchasing PPE and setting up vaccination clinics was done without one single dollar from any other either the Federal or State government. To be clear, we have had some success in receiving reimbursement from FEMA, but this required our Government to upfront the cost. While we were fortunate enough to be able to do this, there is no doubt that Onondaga County would have more greatly benefited if we had received the same direct allocation that our neighbors in Monroe or Erie counties had received.

So there we were, in the middle of a pandemic, with no additional money, forced to let go of staff while enforcing a host of new rules and policies including mask-wearing and physical distancing, necessary to keep our community safe. No upside to this, really, except that when businesses were finally able to reopen, they understood what was at stake. We did institute a system for residents to send concerns or complaints about establishments not following safety guidelines and we teamed up our legal, probation, and health departments to investigate them. State agencies would eventually also lean on us about complaints they received, asking us to investigate. More often than not, we learned our business owners simply did not understand or know all of the new rules they were being required to follow and after empowering them with the necessary information, they quickly and gladly complied. At the end of the day I am proud to say that our local restaurant industry quickly and willingly agreed to be our partners when it came to following and enforcing the rules. Neither we nor the restaurant owners had any interest in seeing them closed again and we worked together to make sure that didn't happen.

As difficult as this past year has been, as a county we have many things of which to be proud. On top of the list is how the community came together, everyone pulling in the same direction. We planned and prepared for the needs of our residents, and we acted. There was no paralysis. Whatever the obstacle, we figured out a way to get it done. We were especially aggressive about testing—symptomatic and asymptomatic—which is one reason why we saw our positive infection rates drop as we began our restart. We were intent on finding those hidden asymptomatic cases because we saw what the virus was doing to our seniors. Therefore, we tested in assisted living facilities and independent living facilities to box in the virus. We were equally aggressive in our schools. We deployed county personnel to perform saliva-pool testing for teachers to start the school year and asymptomatic testing for the entire student body, teachers, and staff beginning in November. Simultaneously, we were building up the infrastructure every day so that we could quickly pivot once the vaccine arrived.

Syracuse University was also planning on using the UpState Saliva Test to bring their students back in August, an effort which would provide a desperately-needed boost to our local economy. However, it had yet to get emergency approval from the State or the FDA. Two weeks before school started, they had a decision to make. We were telling them they needed to test the students before they came back and we knew it was a big ask because it was going to cost them $2 million. Syracuse

University proved once again their commitment to our community and spent the money doing the right thing for public health. Testing kits were mailed to the student's home, they self-administered the test, sent them back and were subsequently sent the results. Our community then knew which students were positive before they returned and required them to stay home and isolate. Those with a negative test were allowed to return, but our efforts did not end there. When the kids got to campus, they were tested again and thanks to this impressive undertaking, Syracuse had a great start to the school year

We were also able to give some relief to small businesses, especially our hard-hit restaurants which are an important source of pleasure for our residents and tax money for the county. The Industrial Development Agency appropriated $500,000 to cover the cost of COVID-related expenses—tents, heaters, fire pits, and more, so that outdoor dining could be more comfortable and compensate for the loss of capacity indoors.

While nothing has made me sadder than the hundreds of people we have lost to COVID–19, nothing makes me happier than to start quickly dispensing the vaccine so we can begin to reclaim our lives and move forward, together. Our community spent months planning, preparing, and mitigating; now our focus has shifted to equitably distributing the vaccine.

Onondaga County has proven to be the best among the big counties in New York State in distributing the vaccine and doing so quickly. I think that is worth repeating, Onondaga County, with no additional dollars or resources, is the best among the big counties in New York State for distributing the vaccine and doing so quickly. In the past 2 months our POD has administered more than 20,000 first doses. While we are proud of this effort, we have the ability to ramp up to 18,000 shots a week. We just need supply. As I said earlier, it is local governments who are responsible for being on the front lines fighting this pandemic. It is literally the job of your local health and emergency management departments to plan, prepare, and train for such events as this. We are on the ground, doing the work, day in and day out to keep our community safe and eventually reclaim our lives.

I want to conclude by taking this opportunity, with this audience, to thank the amazing team working for Onondaga County. They have worked countless hours, had many sleepless nights, and sacrificed a great deal for the good of our community and I am eternally grateful to be able to lead such an amazing and dedicated team. To Chairman Thompson, Ranking Member Katko, and the rest of the committee, thank you again for the opportunity to share my community's story and I am happy to answer any questions.

Chairman THOMPSON. Thank you very much. I thank the witness for his testimony.

I remind each Member that he or she will have 5 minutes to question the witnesses.

I will now recognize myself for questions.

Dr. Ezike, a year later in this pandemic, what more can the Federal Government do to help States like Illinois deliver vital medical care to those hospitalized by the virus and support State vaccination efforts?

Dr. EZIKE. Thank you for that question.

So there is a plethora of needs that can be coordinated at the Federal level. Of course, as I mentioned in comments, we need Federal strategies that help unify the effort of the cities, which in turn unifies the efforts at the local level. We know that in terms of the variants, we need a very organized system of surveillance to identify ahead of time variants mutations as they come on board. We need to be able to collect all the different variants that are identified throughout the State in a very robust library to be able to track that.

We need data. We need a comprehensive data technology upgrade such that we can have our systems, or State registries give the important information to the Federal Government so that we can see exactly what is happening across the country. We know that people live and work in different States and so being able to

have a more seamless connection between our partners is also necessary. But the technology solutions are one of our biggest needs, the technology solutions to make sure that we can collate all this important information.

Chairman THOMPSON. Thank you very much.

Dr. Watson, based on your research, can you explain how America ended up with the highest number of COVID–19 cases and deaths in the world? What should have been done differently and what must be done now to overcome these mistakes?

Ms. WATSON. Thank you for that question, Chairman.

I think it is obviously a combination of factors. But I do think high-level communication about the pandemic was very muddled, sometimes it undermined the advice of public health experts, and it did not help people to take the protections that they needed to take to keep themselves safe from becoming infected. So we have really seen this virus thrive in that type of communication environment.

We have also seen support for public health agencies has not be enough. They do not have the resources they need to do testing at a level they needed to help keep people to stay home when they have been infected or have been exposed to the virus, to do contact tracing at a high-enough level to keep up with cases and contact. All of these things need to improve. We are seeing more direct and clear communication to the public now, but that must continue. We need to be able to back fill health departments who have been going into the red to try and conduct this response. Obviously that is also needed for vaccination efforts, which are still under-supported and need to ramp over the next month.

Chairman THOMPSON. Thank you very much.

I would like to hear from Mr. McMahon. As you know, FEMA is paying for 100 percent reimbursement for the costs associated with this pandemic. Are you current in your reimbursement requests? Or explain how that process is working for local government.

Mr. MCMAHON. Thank you, Mr. Chairman for the question.

Recently we were approved for our FEMA reimbursement for 75 percent. Essentially President Biden I believe—whether it was an Executive Order—pushed us to potentially be eligible for 100 percent reimbursement for our expenses that were spent in 2020. I think one of the challenges, if you think about the way we budget in local government, in 2020 we never budgeted for COVID–19 pandemic response. We then had economic shut-downs. In New York State for local governments our largest driver of revenue is sales tax. So when our economies were shut down, we lost up to 40 percent of sales tax for that period of time. So we never budgeted for these expenses to begin with, so there was never revenue behind it. We then lost the flexible revenue and had to make cuts, mid-year cuts to our budgets.

So even though now we may be receiving some response from FEMA at this point, the model is challenging in the middle of a pandemic to cash-flow expenses. Governments had to borrow at times to cover expenses due to the model of reimbursement. So certainly something that should be considered moving forward.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the Ranking Member of the full committee, the gentleman from New York, Mr. Katko, for questions.

Mr. KATKO. Thank you, Mr. Chairman, and thank you to all the witnesses for the testimony. This is obviously vitally important to getting an understanding of what we can do better.

County Executive McMahon, we have had many conversations over the past year and many meetings over the past year about some of the things you touched upon in your testimony, which I would like to highlight.

The overarching observation from me from all those conversations and meetings is that there is a question of equitable distribution of supplies, equitable distribution of vaccines, and equitable distribution of funding that we have provided. You have highlighted a little bit about the CARES Act funding that went to New York State, but since you were just under the threshold of 500,000, you didn't get the funding directly like your neighbors to the west of you did, Rochester, and that had a dramatically negative impact on your budget.

So you have touched on that, but I want to talk about FEMA's role in this equitable distribution. It seems to me like FEMA is somewhat hamstrung in their ability to equitably distribute the vaccination, equitably distribute the PPE because the New York State—goes to Albany and they decide who gets what and when and how much. I think a lot more of it went down-State than it should have. So, from an equitable distribution standpoint, could you tell us some of the shortcomings you have experienced and what you have had to do to try and overcome them?

Mr. MCMAHON. Yes. So it is difficult, too, if you think about the beginning part of the pandemic when you have PPE and test kits were the big need. The challenge in our State was that New York City and down-State, Long Island, Hudson Valley, was really under siege at a greater level, so the State's attention went to that—appropriately went to those regions, but we still had challenges where were so. So the model of—in an emergency, in a pandemic, of just flowing things through the State doesn't necessarily mean it gets to every part of the State. We saw that with the CARES Act funding. Again, I know there are Members of the committee who represent Nassau County. Imagine if Nassau County didn't receive direct aid in the CARES Act because you would have received from my counterparts. We were the largest community in the country that didn't. So we had to mid-year budget cuts of $40 million in the middle of a pandemic response because we didn't get the help other communities got throughout the country.

When you look at vaccine distribution, our frustration isn't at the point the speed, supply is an issue everywhere, it is that for everything and every curve ball we have been thrown during this pandemic, the one thing county governments were prepared to do was vaccinate. We plan and we prepare for that, whether it was Ebola or whether it was SARS, this is what we do. We get Federal funding to plan and prepare. We believe we should have taken a larger role in that, and we still think we can. Especially we think we should, specifically to the idea that we know how to vaccinate our most vulnerable communities better than anyone else because we work with them every day.

So with vaccinations—I use sports analogies a lot—we are in the second quarter of a four-quarter game here. We can learn from what didn't work well in the first quarter and adapt and adjust and pivot to have great success.

Mr. KATKO. OK. To follow up on that a little more, FEMA doesn't have the discretion with respect to PPE or with respect to vaccinations, in at New York State at least, to decide where they go. To kind-of think about Chairman Thompson's point, I think because of that sometimes minority populations do suffer because of the lack of equitable distribution of the PPE and the vaccinations.

So would it be fair to say that if FEMA had a little more discretion when an emergency declaration is declared with respect to equitably distributing the products? A better mechanism for that would help communities like yours? The smaller ones in New York State?

Mr. MCMAHON. Yes. The intention is to get supply directly to us from the Federal level. The clearest path to do that is to give it to us. I understand the challenge of there are 50 States and there are thousands of local governments with health departments. I appreciate that challenge, but logistically in a pandemic I think it is different from regular course of business funding models.

Mr. KATKO. Right. Just to put a little finer point on that, FEMA is dealing with its first—I think first—National disaster declaration. It means Nationally they are in charge of getting the stuff out to the front lines, the vaccinations, the PPE, and everything. It seems to me that given that model the communities like yours and communities like—Chairman Thompson talked about Mississippi—they should have more discretion instead of being held to the whims of a Governor or a legislature that may not be as competent at doing that.

Then from a fundamental sense of fairness, teams should have more role in deciding how things get distributed in the State. Is that fair to say?

Mr. MCMAHON. I think it would beneficial during the pandemic, from my experience. Not suggesting—we may do some things differently. Whether they are better than the State will do then, history will judge us all on that. I just think the reality is local health departments, these are our professionals. We have epidemiologists on staff. Our local health commissioner and their team, they are the best in the business in my opinion. We know how to get things done. This is our community.

I am a county executive. I am accountable to every member of the public here. We have certain powers in a public health crisis that have even been somewhat challenged through the State emergency orders.

So the intention of the Federal Government is to get funding to local health departments in an emergency. The easiest way to do that is to get the funding to us. There is no guarantee if it doesn't go to us that the intention from the Federal Government, that will is going to actually happen.

Mr. KATKO. Thank you very much, Mr. McMahon. I appreciate all you have done during this pandemic.

Now, Mr. Chairman, I yield back. Thank you.

Chairman THOMPSON. Thank you very much.

The Chair will now recognize other Members for questions they may wish to ask the witnesses. I will recognize Members in order of seniority, alternating between Majority and Minority. Members are reminded to unmute themselves when recognized for questioning and to then mute themselves once they have finished speaking and to leave their cameras on so they are visible to the chair.

The Chair now recognizes for 5 minutes the gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Thank you very much and good morning. Thank you to all of the witnesses for your very important testimony.

Texas remains a hot spot in the landscape of COVID–19 cases. It is a State of almost 29 million persons and we have had 41,000 deaths and we continue to be a hot spot for infection and of course we are challenged as it relates to the hard-to-reach communities and people of color.

So this is a very important hearing because we are not ending, we are beginning. I think this committee has to be very pivotal in that role.

Let me ask Ms. Clowers of the GAO, regarding the issue of testing, just the memory lane, very briefly, if I might, where we went wrong in the testing protocol when COVID–19 first started. You had recommendations of GAO reporting regarding testing and where they were implemented. What were your recommendations, very briefly, and are they valid today?

Ms. CLOWERS. Yes, they remain valid. One of the key recommendations that we made was for a National strategy. You have heard the other panel members talk about this need as well. There has been different testing strategy documents that have been put out, but not an overarching strategy that would contain all the information that you would expect from a comprehensive strategy, where it defines the goals and the problems and the risk and the benchmarks, as well as how are we going to fund this, what resources are needed. Defining the roles and responsibilities. Then, importantly, making that strategy publicly available.

One of the things we found in our work in talking to non-Federal stakeholders is that sometimes they weren't clear about their role in a National strategy and that is, you know, ripe for causing confusion and gaps. That is what you can't have during a public health emergency.

Ms. JACKSON LEE. If I might, the failure in the administration not having a testing protocol provided for the surge in COVID-positive cases.

Ms. CLOWERS. The lack——

Ms. JACKSON LEE. No protocol, no—that——

Ms. CLOWERS. I am sorry to interrupt. The lack of the strategy has certainly compounded the problems that we were seeing. As you know, from the start, the testing in our country had challenges with the roll-out of the test equipment from CDC that caused some inaccuracies and to the slow ramp-up, and then we got into the supply chain. So it was a snowballing effect.

Ms. JACKSON LEE. Thank you, thank you very much.

Ms. CLOWERS. Mm-hmm.

Ms. JACKSON LEE. Mr. McMahon, I was moved, impressed by your testimony. You are obviously boots on the ground and we thank you for that.

I introduced H.R. 936, delivering COVID–19 vaccinations to all regions in vulnerable communities, which really was to emphasize FEMA working directly with local counties and cities where you are managing your own health department.

Can you dig a little deeper on how that would work, rather than waiting with hat in hand, as you had to do for PPE, as you had to do for testing test kits, and now vaccines. Would that help save lives? We failed to do that with the Trump administration. We saw that as Members of the Congress, but you, how do you see the idea of getting direct collaboration with the Federal Government through FEMA and reaching these hard-to-serve communities, vulnerable communities?

Mr. MCMAHON. Thank you for the question and thank you for your service.

I believe the reality is that we could be partners at the local level with the Federal Government. I have colleagues that we communicate throughout the country and they may be called county judges in different parts of the country or different things, but I have spoken to the Harris County executive or county judge about the challenges via our network that we have. We have the local health departments, the experts. My health commissioner is a graduate of Johns Hopkins. She is well renowned. We have followed the data in this process. We have looked at testing as the tool to identify and box in the virus, the risk to our community. Getting us the vaccine directly will certainly help us get to the communities that need to get it that are not participating at the right levels.

Ms. JACKSON LEE. Thank you.

Mr. MCMAHON. Thank you, ma'am.

Ms. JACKSON LEE. Thank you.

Dr. Watson, are we sicker now because we did not have protocols dealing with COVID–19 early on? Is America sicker now, lost more lives because of that?

Ms. WATSON. I think there is no question of that, representative, that we have experienced a lot of illness and death, not just from COVID but also from loss of access to health care for other diseases that are critical. Absolutely.

Ms. JACKSON LEE. Thank you. Mr. Chairman, may I submit into the record Delivering COVID–19 Vaccinations to All Regions and Vulnerable Communities Act? I ask unanimous consent.

Chairman THOMPSON. Without objection.

[The information follows:]

I

117TH CONGRESS
1ST SESSION

H. R. 936

To direct the Federal Emergency Management Agency to assist States and local governments with the distribution and tracking of vaccines for COVID–19, to direct the Secretary of Health and Human Services to carry out a national program to oversee the collection and maintenance of all Federal and State data on vaccinations of individuals in the United States for COVID–19 to achieve mass vaccination saturation immunity, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2021

Ms. JACKSON LEE (for herself, Mr. PAYNE, Mr. BROWN, and Mr. JONES) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To direct the Federal Emergency Management Agency to assist States and local governments with the distribution and tracking of vaccines for COVID–19, to direct the Secretary of Health and Human Services to carry out a national program to oversee the collection and maintenance of all Federal and State data on vaccinations of individuals in the United States for COVID–19 to achieve mass vaccination saturation immunity, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Delivering COVID–19 Vaccinations to All Regions and Vulnerable Communities Act of 2021" or the "COVID–19 Delivery Act".

SEC. 2. FEMA ASSISTANCE FOR COVID–19 VACCINATIONS.

In the assistance to State and local governments, the Administrator of the Federal Emergency Management Agency shall—

(1) coordinate efforts for vaccine delivery, including from manufacturing sites to inoculation sites;

(2) monitor shipments of vaccines through a 24-hour tracking system, including readings on the temperature, real-time location, origin, destination data, anticipated time of arrival, and report to recipients on changes and updates on the progress of their delivery shipments and any changes that may impact expected delivery or the viability of the vaccine while in transit;

(3) develop an advanced communication system to allow the Department of Health and Human Services and public health departments to communicate and share information about vaccine readi-

ness, capability of receiving vaccines, delivery locations, details of facility capability of storing and securing vaccines, personnel authorized to receive deliveries, logisties for delivering vaccines to patients, report on vaccine receipts, condition of vaccines, patient reactions, and feedback on how to improve the process;

(4) secure transportation for delivery or use of vaccines, and if requested, security for the vaccine delivery sites or inoculation locations to ensure the life and safety of personnel and patients who seek to provide or receive vaccinations free of interference or threat;

(5) design custom software applications (Apps) with the Department of Health and Human Services for use by public health agencies and any company or person administering vaccines to provide information to patients on the vaccine being received, the date of a second dose and the location of the dose if required, including generating a token that corresponds to an individual's vaccination record to ensure that the right vaccine is administered and if a second inoculation is required and to ensure that an individual is not vaccinated with different vaccines,

and any additional information that may be pertinent in the future;

(6) develop a public education and patient engagement program about the safety and availability of vaccines that also ensures that individuals in areas and locations where vulnerable populations often do not have easy access to health care or vaccinations are informed about vaccine availability; and

(7) acting through the Department of Health and Human Services, provide additional vaccination centers, in addition to State and local government sites, to augment vaccinations occurring within such States and local governments to address access to at-risk communities when vaccination rates are below 80 percent for a population residing with in a census block or track that is experiencing a greater incidence of serious complications, such as hospitalizations and deaths that are above the proportional representation of the at-risk group when compared to the general population, establishing the need for a targeted vaccination effort to reduce the incidence of infections for those individuals at greatest risk for hospitalizations and death from COVID–19.

SEC. 3. CDC REQUIREMENTS.

The Centers for Disease Control and Prevention shall track the dissemination of inoculations and report on efficiencies, effectiveness, or deficiencies of local and state COVID–19 vaccination programs, including the availability of certified individuals under Federal, State or territorial authority to administer a vaccination under State law, and report to Congressional oversight committees in the House of Representatives and the Senate on findings and recommendations.

SEC. 4. HHS MANAGEMENT OF COVID–19 VACCINATION DATA TO ACHIEVE MASS VACCINATION SATURATION IMMUNITY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall carry out a national program to oversee the collection and maintenance of all Federal and State data on vaccinations of individuals in the United States for COVID–19, including tracking booster vaccinations, to achieve mass vaccination saturation immunity.

(b) APPLICABLE PRIVACY LAW; PENALTIES.—

(1) IN GENERAL.—The Secretary shall maintain data on vaccinations for COVID–19 in accordance with all applicable privacy and security law, including HIPAA privacy and security law (as defined

in section 3009(a)(2) of the Public Health Service Act (42 U.S.C. 300jj–19(a)(2)).

(2) PENALTIES.—Any person who discloses or uses data on vaccinations for COVID–19 in violation of any provision of law referred to in paragraph (1)—

(A) shall be imprisoned for not more than 5 years, or fined in accordance with title 18, or both; and

(B) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation.

(c) DATA RETENTION LIMITATION.—The Secretary shall destroy any data maintained pursuant to subsection (a) by the end of the 5-year period beginning on the date of receipt or collection of the data, whichever is later.

(d) TRANSMISSION OF STATE DATA.—The Secretary shall take such steps as may be necessary to encourage and assist each State in transmitting to the Secretary on an ongoing basis the State's data with respect to vaccination of individuals in such State for COVID–19.

(e) OMBUDSMAN.—The Secretary shall appoint an ombudsman to—

(1) support public and stakeholder input on the activities carried out pursuant to this section;

(2) provide advocacy and advice for those who elect not to be vaccinated for COVID–19; and

(3) champion the privacy and civil liberty rights of individuals in the United States in connection with vaccination for COVID–19.

(f) COLLABORATION.—In carrying out this section, the Secretary shall collaborate with stakeholders in establishing vaccine inoculation centers in locations including—

(1) stadiums, arenas, elementary and secondary schools, colleges and universities, and places of worship; and

(2) other locations determined by the Secretary to be condcive to reaching the greatest number of people in need of inoculations for COVID–19.

(g) ADVISORY BOARD.—For the purpose achieving mass vaccination saturation immunity to COVID–19 in the United States, the Secretary shall establish a stakeholder advisory board to support the collaboration and cooperation of entities including Federal, State, and local governments, businesses, colleges, universities, elementary and secondary schools, hospitals, clinics, professional medical associations, and such other entities as the Secretary determines to be essential to such purpose.

(h) REPORTS.—On a daily or weekly basis, subject to subsection (b), the Secretary shall submit to the Congress and make public reports on the activities carried out under this section, including such data as the Director of the Centers for Disease Control and Prevention determines to be relevant to analyzing inoculation statistics and progress toward achieving mass vaccination saturation immunity.

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Ms. JACKSON LEE. Thank you.

I yield back, Mr. Chairman. Thank you.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentleman from Louisiana, Mr. Higgins, for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman, Mr. Ranking Member.

We have shut down the world's economy and destroyed millions of American families' lives over a virus. Far beyond health concerns of the virus, 100 million American adults having difficulties covering their household expenses, millions of children are missing out on critical in-person education. The economic consequences of Government action in response to this virus is going to last a generation. Viruses come and go. There is a certain cycle, new virus im-

pacts the world, the world responds. We are in the 21st Century now, we have unbelievable medical skills and technologies, we are responding very quickly, and yet we shut down the world's economies. Despite Americans being told to stay home—let me tie this together with what is going on at the border—America is being told to stay home and shut down their businesses, deny their children an education, but our newly-inaugurated President is right now allowing scores of thousands of migrants, illegal immigrants, who had been held in Mexico and attempted to enter our country illegally, allowing them access into America. We are a Nation of immigrants, a Nation of compassion, and I am willing to have that conversation about immigration laws with my colleagues, but I find it highly ironic that Americans are being asked to live under continued repressive COVID restrictions while the Biden administration has relaxed our borders in a way that will result in a mass migration of people from Central and South America. Nobody is talking about COVID there.

We expect illegal immigrants to enter America relatively freely, then we should let American citizens ourselves live free.

Families have been restricted from the death beds of their loved ones. It is an unbelievable emotional impact. At any other time my colleagues were talking about the—be talking about the emotional stress and the pain and the burden of anything imaginable, but no one is talking about this. It has been abhorrent the oppression of freedoms and the impact on American families. My colleagues and the respected panelists that mention statistics, statistics stating that the United States is worst in the world, statistics are very commonly lies. Compared to who? China? Seriously? Does anyone believe that any COVID data coming out of China is accurate? It is intellectually unsound.

What is next, Mr. Chairman? What virus is next? What level of Government oppression is next? Many, many Americans believe that their Government does not want them to wear masks and tolerate un-Constitutional restriction of freedoms until the end of COVID, many Americans believe that governments wants us to wear masks and tolerate oppression until the end of time.

We grow weary.

Mr. McMahon, let us talk about our kids please.

Mr. MCMAHON. Yes, sir.

Mr. HIGGINS. Let us talk about the schools. Students have the highest risk of long-term negative effects due to Government actions in response to COVID. Parents unable to go back to work because their kids are not allowed to go back to school.

Give us your opinion, share with America, how do we get our kids back in school? You mentioned in your opening statement regarding Syracuse University. Share some of that formula——

Mr. MCMAHON. Sure.

Mr. HIGGINS [continuing]. And how we can get our kids back in school please.

Mr. MCMAHON. Thank you. Thank you for your service as well.

The reality is that throughout the pandemic response on every issue we follow the data. The more data we can get, you can make better decisions and you find the appropriate balance at the appropriate time during the pandemic response. Certainly we are at a

position now when we—over—getting, for example, higher education back into the community. We worked with Syracuse University to send test kits to every student throughout the country. They were tested. Those who tested positive needed to quarantine at home. The students then came back to the community that were negative. They were then tested again. Now we do weekly testing for higher ed so that these students can have an in-person experience.

When you look at our Pre-K–12, in our community we have been going to school. Some of our smaller rural districts, due to the regulations set forth by the State, can meet in person 5 days a week because of the physical space. Some of the larger districts have hybrid models where they are going in person 2 days. Some in our urban districts, the model changed from a remote model to a hybrid model. We are very concerned about the hybrid models. We know our children are falling behind. We know that we have rising cases of child abuse. Our eyes and ears on our children are our educators, day in and day out. We need them in the game. Our kids need to be learning.

So we look at the data. Like I said before, what we did before our Pre-K–12 started in the fall, we tested all the faculty going back. We have done random asymptomatic saliva testing in the school buildings to look for that asymptomatic carrier. Now we have been using the Binax antigen test on a weekly basis with our county teams going in with our schools to test asymptomatic students. Mind you, a symptomatic student is not allowed in the building. So our positivity rates in the schools, from the month of January 2021 to present, even though we were experiencing surges in the community, our positivity rates in the schools is really about a 0.2 percent, trending down.

So we believe testing is the tool to keep schools open. You give the data to the public so the public feels comfortable about doing more in-person learning.

Mr. HIGGINS. Thank you, sir.

Chairman THOMPSON. The gentleman's time has expired.

Let me caution the Members, if you speak for 4 minutes and ask a question that takes 3 minutes, you are not being fair to the next Member of the committee. So I am going to hold us to the 5-minute mark because we have a lot of Members, because we are in a full committee, who need to get a chance to ask their question.

So the Chair will now recognize the gentleman from Rhode Island, Mr. Langevin, for 5 minutes.

Mr. LANGEVIN. Thank you, Mr. Chairman. I want to thank our witnesses for their testimony today.

I want to turn our attention to how the disabilities community has been impacted by COVID in particular. Unfortunately, many of the 500,000 people that we have lost to COVID belong to the disability community. Reporting by, for example, NPR, shows that people with intellectual disabilities and autism dying from COVID–19 at higher rates than the general population. In early numbers from the United Kingdom show that people with disabilities accounted for nearly 60 percent of all COVID–19 deaths last year. A very sobering statistic indeed.

As we continue working to provide an equitable response to the pandemic, I believe it is essential that we include the disability community in our conversation.

So, Ms. Clowers, if I could start with you, in your testimony you discussed CDC data that illuminate the disparity in COVID–19 in cases, hospitalizations, and deaths when examined by race and ethnicity. Would standardized COVID–19 data broken down by disability status also be useful in ensuring an equitable pandemic response?

Ms. CLOWERS. Yes, sir, it would. We need better, more granular data on a variety of fronts, whether it is with the disabled population, different racial or ethnic groups. Without that data it limits our ability to take needed corrective action to monitor trends, to see where we are maybe experiencing problems and then attack those——

Mr. LANGEVIN. Thank you. Are you aware of any CDC data or reporting efforts that examine COVID–19 cases, hospitalizations, or death by disability status?

Ms. CLOWERS. I have not seen that, but I will ask my team. We will comb through the data again and get back to you if we find it.

Mr. LANGEVIN. OK. I would appreciate that.

Ms. CLOWERS. Mm-hmm.

Mr. LANGEVIN. I think that would be very helpful. I will say that the American Community Survey conducted by the U.S. Census Bureau examines difficulties in 6 categories, hearing, vision, cognitive, ambulatory, self care, and independent living. I wanted to mention that.

Dr. Ezike, if I could, has the Illinois Department of Public Health been tracking data on the prevalence of COVID–19 cases, infections in the disability community? Why did the State feel it was important to prioritize vaccination for individuals with disabilities?

Dr. EZIKE. Yes, sir. Thank you.

So we absolutely thought that this was an important group that needed special attention beyond individuals who are in a congregate care facility. So that is why we intentionally moved the group of differently abled or disabled population into our 1D category. With our forms of registrations for vaccination, we will be able to select—people will have to designate their eligibility for vaccination, so they will be able to check if disability is the eligibility criteria that they need. So we will be able to grow some information and data around that. That eligibility population begins tomorrow.

Mr. LANGEVIN. OK. That is helpful information. Hopefully I will get some—we will look to that going forward.

Let me ask you this, it has also been reported that roughly a third of Americans—military personnel are declining to receive coronavirus vaccines when they are offered, which is certainly above the civilian population.

Dr. Watson, if I could ask you, from a public health perspective, what could we do to ensure that our troops understand the importance of receiving a COVID–19 vaccine and feel comfortable about its safety and efficacy? This is also important given the fact that we are using the National Guard, for example, to help implement

and assist with the COVID–19 response, but also administering the vaccine.

Ms. WATSON. Thank you for that question.

Yes, I think it is all about clear and consistent communication. It is also about speaking with individuals who have familiarity with groups that we want to reach who are trusted by those communities. So we need to reach out to community leaders and give them the information that they can pass on and have conversation with people to try and understand their hesitancy. Then give them data and information that can show them how safe and effective these vaccines are and why it is important for them to be vaccinated.

Mr. LANGEVIN. Yes. Very important. Especially as it could impact readiness and response.

So I know my time has expired. Thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentleman from Mississippi for 5 minutes, Mr. Guest.

You need to unmute yourself.

Mr. GUEST. Thank you.

Dr. Watson, in your testimony, on page 3 of your written testimony that you submitted, you have a paragraph that says what we are doing right now in the United States, and you talk about some of our recent successes. It says the number of U.S. cases, hospitalizations, and deaths are all dropping rapidly from a winter peak, which was the highest of the pandemic. Daily numbers have fallen from a high of 295,000 reported on January 8 to about 72,000 as of January 20. Similarly, hospitalizations came down from a dramatic National average of about 130,000 to 63,000. Deaths are following, having dropped from a 7-day average of about 3,500 a day to about 2,000 per day.

You also go on in the following paragraph to talk about an increase in population immunity from vaccination and prior infections. You say as of February 20 about 12.9 percent of the United States population has been vaccinated and more people in the United States have now received at least one dose in the vaccine in number of people reported to have had COVID.

Recent media reports as it relates to school reopenings, the *Wall Street Journal* said parents and officials in favor of reopening in-person education say their own experiences confirmed research that children are being harmed academically, emotionally, physically by the isolation of remote learning. Kids, they argue, need to be back in the classroom as soon as possible. They point to the U.S. Center for Disease Control and Prevention recent urging of schools to reopen under new safety guidelines and research that shows low transmission in schools where safety protocols are followed.

ABC News reported that the Nation's top health agency said that in-person school learning can resume safely with masks, social distancing, and other strategies and vaccination of teachers, while important, is not a prerequisite to reopening schools.

In my home State of Mississippi, the Chairman's home State of Mississippi, my son's high school, we have been successfully implementing in-person learning since August. So August, September,

October, November, December, January, February, now heading in to March—for 8 months in the State of Mississippi we have been able to successfully implement in-person learning. Congress has appropriated $70 billion for K–12 schools to implement and to educate our children during this pandemic.

So my question is, in light of the recent successes that you listed in your report, in light of the new CDC guidelines, in light of the fact that Congress has appropriated $70 billion, why are we still unable to reopen our schools in many parts of the country?

Ms. WATSON. That is a good question. Thank you very much.

I think that we still have very high incidents of this virus in our communities, and so as incidents continue to drop—it is not low yet, but as it continues to drop, it makes in-person learning much safer. I agree with you that when schools follow the CDC guidelines, when they are testing frequently, and especially now that we have vaccines, when adults can become vaccinated in schools, that in-person learning will become much more viable and much safer.

So I think we are definitely headed on the path to resuming in-person learning for most schools across the country, but we have to do it safely. That is through following the CDC guidelines.

Mr. GUEST. But do you agree that children that are educated remotely, that they suffer harm academically, emotionally, and physically because of the remoteness? Would you also agree that there are many children who learn much better in in-person classroom settings than they do remotely?

Ms. WATSON. I think that there is no doubt that in-person learning is what we are all striving for and what kids need. We just have to make sure that we are getting back to it safely, and I think we are on the path to that.

Mr. GUEST. Well, then why are schools, such as the schools in Mississippi, again where my son has been enrolled in-person learning since August, why are some schools able to be very successful in that and other schools are even reluctant to try in-person learning? Because it seems like, from the recent CDC guidelines and the new research that we are getting, that schools can reopen safety, but is it reluctance on the behalf of many of the educators, many of the school boards to force schools to reopen and to educate our children as we are required to do?

Ms. WATSON. The guidance is also dependent on lower levels of transmission in the community, as well as comfort by teachers and other adults who have to be in the room, as well as parents in sending their kids to those schools. So it has to be a conversation with people. We can't force people to come back in person if they are not comfortable.

Mr. GUEST. Thank you, Mr. Chairman. My time is up, I yield back.

Chairman THOMPSON. Thank you very much.

Chair recognizes the gentleman from New Jersey for 5 minutes, Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

Listening to my colleague, I would be remiss if I didn't mention that had the 45th President taken seriously this pandemic, we could potentially not be in this condition: 505,000 people have succumbed to this disease. The 44th President met with the 45th

President's administration and laid out 3 different incidents of disaster that could happen in the country. One was a pandemic scenario. But it was never taken seriously by the 45th President, and here we are.

So my question is for Dr. Ezike and Dr. Watson. To get our children back into school is critical, but we must do it safely, obviously. President Trump pushed schools to reopen, but without funding States and local governments need to ensure distancing in schools and enough PPE for students and educators. He would not even reimburse State and local government for the costs necessary to operate school safely, such as masks or disinfectant.

My piece of legislation, the Masks for Students Act, which passed the House unanimously last Congress, and a part of FEMA Assistance Relief Act, will require FEMA to reimburse school districts for the cost of masks. I am pleased that President Biden has followed our lead and directed FEMA to reimburse schools for these operating costs.

Dr. Ezike and Dr. Watson, can you explain to the committee why it is important for the Federal Government to help schools pay for mitigation measures like masks and disinfectant supplies?

Dr. EZIKE. Thank you, Representative.

This is an important measure that is needed because all school districts are not created equally. We know we have school districts in high socioeconomic areas versus very low socioeconomic areas. So the ability to have these supplies up and ready without the assistance is very varied. We know that class sizes, classroom size, the ability to do testing, a lot of those measures have been able to be done in higher economic areas, which causes the increased disparities.

So we do agree that resources should be deployed so that is not another defining division to be making students have opportunities to be in person learning versus others, because we do all agree that that is where we want our kids to be.

Mr. PAYNE. Thank you.

Dr. Watson.

Ms. WATSON. Thank you very much.

I completely agree with my colleague. I also think that we need to give consistent guidance to school districts across the country that is coming from the Federal level, which I believe we now have, but also from the State and local level, which has been quite variable. So if we can make clear our expectations of the steps that schools can take to keep their students safe, and then of course have the resources to do that, I think that will be very helpful.

Mr. PAYNE. Thank you.

Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you. The gentleman yields back.

The Chair recognizes the gentleman from North Carolina, Mr. Bishop, for 5 minutes.

Mr. BISHOP. Thank you, Mr. Chairman.

Dr. Watson, your testimony happened to be first in my packet and I read it with care. On the first page you say that significantly though we have offered up evidence that our National response did not meet its potential and that many thousands of unnecessary

deaths have occurred as a result. I read with care specifically those parts of your testimony that spoke about successes and failures.

I note I guess the—is this paragraph on page 5, you say finally—and I think this is—everybody pretty much agrees on this—finally the biggest and most visible success of the past year is the development of multiple, highly safe, and effective COVID–19 vaccines in under a year. I cannot emphasize enough what a technical feat this is. In fact, you have said also otherwise in your report that cases are dropping sharply and hospitalizations are at this point. Is that right?

Ms. WATSON. Yes, that is correct.

Mr. BISHOP. So by historical standards, I mean that is kind-of an unprecedented success, wouldn't you say?

Ms. WATSON. I think the development of the vaccines is absolutely an unprecedented success, yes.

Mr. BISHOP. Now, on the parts about the failures of the U.S. pandemic response, I read that and it is hard for me to condense some of it. I mean it is about the—you said that public health officials suffered retribution and bad treatment, that elected leaders didn't adequately protect and support them, that there was a politically-driven failure to heed expert advice.

I think this is the best summary sentence maybe. It says high-level denial of the severity of the pandemic and disempowerment of scientists and public health experts led to both under-resourcing of the response and significant confusion of the public.

So when you get past that sort-of section on just sort-of the generalities of that, you get into this paragraph that says within the response itself there are a few significant issues that should be highlighted. You say that public health agencies were overburdened and underfunded, and then you come to a specific. You say support for State, territorial, and Tribal vaccination planning is a particularly damaging failure. While the U.S. Government has understandably spent billions of dollars on vaccine development, only $200 million was provided to States for the actual distribution and administration of the vaccine. Is that in fact your testimony? You cite an article, but is that your testimony before the committee, that only $200 million was spent for that?

Ms. WATSON. Was specifically made available for the planning and for mass distribution of the vaccine yes.

Mr. BISHOP. Well, I looked up the article that you cited and it says that that $200 million was released by CDC in September. In fact, there was a September 23 release to that effect. But at the end of the article it goes on to say Congress eventually did allocate $4.5 billion to State governments, but the money only began to flow to the States earlier this month.

So is the figure $200 million or $4.5 billion?

Ms. WATSON. Two hundred million dollars was in reference to the planning phase for mass vaccination back in the fall.

Mr. BISHOP. At the time—I mean if that was only released in September, so the debate that this newspaper article refers to is what was happening in October, right?

Ms. WATSON. Yes, sir.

Mr. BISHOP. I think what caught my attention about it is when I was reading Ms. Flowers' testimony, over on page 5, it says that

FEMA, as of February 7, had provided more than $2.29 billion to 32 States, the District of Columbia, 3 territories, and 2 Tribes for expenses related to COVID–19 vaccination efforts.

So there is another—is that an additional $2.29 billion that—because it didn't come from CDC, but FEMA?

Ms. WATSON. I defer to my colleague, Ms. Flowers, on that. That is a big issue. I would have to go back and look, sir.

Mr. BISHOP. When you were testifying that only $200 million had been given to help distribution efforts, you were intending of course to rely on that information. I assumed you researched it carefully, didn't you?

Ms. WATSON. Yes, sir. That was the funding that came to CDC to States and local—to State health departments to prepare for vaccination efforts, yes.

Mr. BISHOP. Well, I would say that from what I read in your own article and from Ms. Flowers' testimony, that seems to be a misleading figure. I would think, in light of the degree to which you anticipate and expect that rely on you as the expert, that you would be more careful about reporting such a disparity.

I mean we are talking about probably 100 times misnumber or mistake in terms of the amount there.

I notice that—or I point out, I am sure you are aware that in New York State Attorney General Letitia James released a report on the nursing home response there and that a larger number had died than had been reported, that there were suppressions of information by the State government there, because for political reasons that the number of deaths connected to New York nursing homes were about 15,000, up in the—this has ballooned up to that, from 12,743 in late January. So it is an on-going problem. I would think that it would be very important for maintaining trust that accurate and non-partisan, non-slanted information come forward from public health officials in order to justify the confidence and the reliance that you are saying should customarily reported.

Thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. Thank you very much.

Chair recognized the gentleman from California for 5 minutes, Mr. Correa.

Mr. CORREA. Thank you. Thank you, Mr. Chairman, for holding this most important hearing.

Last year, as you know, the first Member of this committee to call for expert testimony about this emerging threat called the coronavirus today, and this committee, thank you very much, sir, was one of the first to hold a committee hearing on the subject matter. A lot has happened in almost a year, a lot of loss, a lot of our friends and neighbors that passed on.

Ms. Clowers, in a GAO report on our COVID response you noted that the previous administration had not acted on recommendations to more fully address critical gaps in the medical supply chain. Lessons learned. Where did the prior administration fall short, what do we do today to fix that?

Ms. CLOWERS. We made several recommendations in the area of medical supply chain, and I will highlight a few where I think if we took some action it would help improve on-going response.

First, clarifying the roles and responsibilities of the number of actors involved. At times there has been a lot of maybe phonetic activity in trying to get the supplies and address the gaps that we are seeing, but they always have not been coordinated, leading to confusion and frustration.

Mr. CORREA. Let me interrupt you there.

Ms. CLOWERS. Sure.

Mr. CORREA. Very quickly. You bring up a good point.

Mr. McMahon, you are a county individual where the rubber meets the road. One of the issues that I see on every weekend that I am not with my county employees trying to vaccinate our communities is, you said, Ms. Clowers, confusion. I am seeing some of the change in the administration's response. This administration to use Federally-qualified health care centers to better communicate, distribute vaccines directly from the Federal Government, those people that are actually giving out the vaccinations. There are too many middle men right now. There are too many different agencies, State, local, counties involved. This is creating all kinds of confusion.

So my question to both of you is can we—how fast can we get the Federal Government to streamline the system, use FQHCs, maybe go directly to those, you know, doctors at the corner that really treat the patients on the day-to-day basis? How can we execute more effectively right now and not have to wait another few weeks to get to an execution that is satisfactory to our community?

You can answer that very quick, Ms. Clowers and Mr. McMahon.

Thank you very much.

Ms. CLOWERS. OK. I will go first if you want and I will just say really quickly it is involving local officials, like Mr. McMahon, in these efforts. To date, a lot of the plans have been developed maybe at the Federal or State levels and not always involving the locals, and the locals are the ones that know their community and can get that message out and help the distribution going.

So I will turn it to my colleague now.

Mr. MCMAHON. I would agree, sir. The reality is our local FQHC has been a great partner of ours. We had the first mobile testing site with them before we had a case. The challenge they would have is capacity. So we at the local level have the capacity, we have the human service relationships in the neighborhoods. The State of New York is working with us potentially on more vaccine supply to address this issue, but we are the ones that have the existing infrastructure that we can build off of, we have the relationships. These are our clients that we work with on a day in and day out in other departments, so really at the local levels the best way and the best strategy to get to our hard-to-reach communities.

Mr. CORREA. Ms. Clowers, we keep talking, we keep reading about these millions of vaccines that are coming our way, yet this last weekend I was at home. Megacenters shutting down because the vaccines were not there. How fast can we ramp up to really take care of this issue? I don't want the blame game, I just want to say how fast can we get the vaccines to main street?

Ms. CLOWERS. Well, I think we heard very positive news out of testimony yesterday from the vaccine development companies in terms of getting to 3 billion in the next month or so. So the supply

is growing, the supply is going to be there. It is really going to come down to these logistics of taking what the supply there and quickly it into the shots and into the arms of Americans. So that is going to involve our local officials, but also importantly the communication. It needs to be very clear and consistent.

As you have heard from fellow panel members in terms of both educating the public on the safety of the vaccine, how to get the vaccine, as well as educating providers and encouraging them to help understand and promote that message as well.

Mr. CORREA. Thank you very much.

Mr. Chairman, I am out of time. I yield.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from South Carolina for 5 minutes.

Mr. NORMAN. Thank you, Chairman, and Ranking Member Katko. Thanks for holding this hearing.

I guess my question concerns the vaccine roll-out. Let me remind my colleagues on the—my friends on the left, that had it not been for Operation Warp Speed to produce this vaccine, there would be no vaccine. So other than the 7-year turnaround, which is normal, to have it within 12 months is really an accomplishment that the 45th President made happen. I just wanted to alert everyone to that.

Let me ask the question as far as the roll-out. We have got right at 3,000 immigrants a day coming across that border due to the Biden administration. I have heard all through this testimony about shortages of vaccines among the minority, shortages among Americans, what are we doing as the 3,000 come across the border who will be entering our school systems, who will be entering our towns? What is our game plan to vaccinate them? Are we using masks? What is happening with that? Because if you look at the statistics—and I am one that follows the data. I think that is a good thing. The new cases domestically, according to the CDC's website, are 67,437. Internationally they are 384,448. You look at the new deaths domestically, 2,356. This is as of February 19. Internationally 10,471. So 5 times the numbers domestically.

So in order to protect America—and, Ms. Clowers, I will address this to you—what is the game plan that you see to fund it for both the illegals coming across the border, and how are we going to deal with this?

Ms. CLOWERS. Well, certainly as we roll out with our vaccine efforts and we are focusing on the United States, as one of the panel members mentioned earlier, this is a global crisis. As long as the pandemic, as the virus is spreading throughout other countries, that poses a security risk and a health and safety risk to us as well. So it is something that we are going to have to watch and participate in.

I know there has been funding that is provided to State and other efforts to help control and mitigate the spread in other countries. It is work that we have on-going and happy to report back to you on this.

Mr. NORMAN. So, specifically, are they being vaccinated as they come across or are they being tested, are they—I mean give me

some—I know you say generally we are looking at it, what are the specifics?

Ms. CLOWERS. Sir, at this point I don't have those details at my ready in terms of what we are doing at the border, but I can certainly get back to you and your staff on that.

Mr. NORMAN. If we could, because it affects every American, it affects—this isn't a Democrat or a Republican issue, this is an American issue. So if you can get back with us on specifically what is being done all across the borders that are now pretty much open for anybody to come across, I would like to see the game plan that you have and others have before it gets to the pandemic—worsens the pandemic that we have here.

Ms. CLOWERS. Yes, sir.

Mr. NORMAN. Now, as we try to get a handle on the funding on how the COVID relief is being spent, was your team at GAO, Ms. Clowers, able to assemble the information that we need to track how the COVID–19 relief funds were actually spent? How was that done?

Ms. CLOWERS. We are doing that—in the process of doing that. As new relief bills have been passed we have been updating our information. As of now about $3.1 trillion has been appropriated and that has gone across the Government, a variety of sectors. HHS has been one of the largest recipients of that given their responsibilities for the public health. We have been tracking that down through the obligations that have been made, as well as expenditures and trying to track that down, all the way down to the State and local governments in some cases.

Mr. NORMAN. On the unspent funds, do you know the amount of unspent funds and when that is going to be released?

Ms. CLOWERS. In terms of—I can give you some information on that in terms of the amount that has been obligated. Just as a little bit of data, because we are still updating the information, but as of November 30, so far at that point $2.7 trillion had been appropriated, about $1.9 trillion had been obligated, and $1.7 had been expended. We will be updating that with new release consolidated act numbers that were passed at the end of December.

Mr. NORMAN. OK. Well, I would ask if you could get this. When do you think you would have this information?

Ms. CLOWERS. Yes, sir, we will be reporting out again in March. Congress directed us to report on a regular basis and our next report will have the latest spending figures in it. We will make sure to get that to you and happy to brief you and your staff on it as well.

Mr. NORMAN. On the actual plans on the treating the illegals, will that be to us?

Ms. CLOWERS. Yes. I can get that to you as soon as I get back to my team and get some specifics in terms of what the agencies are doing and I will follow up with your staff.

Mr. NORMAN. Great. Thank you so much.

I yield back.

Chairman THOMPSON. Thank you very much.

Ms. Watson, I did not give you time to respond to the testimony referencing the CDC expenditure for the vaccine. If you would like to respond to that, I will yield back to you.

Ms. WATSON. Thank you very much, Chairman.

Yes, I specifically worked on the funding that went to State health departments to prepare for the vaccine roll out. So at that time it was a very small amount compared to what had been spent on vaccine development. That development was obviously very important. I am not taking away from that, but we did not adequately reimburse our health departments to undertake the unprecedented roll out of vaccine, certainly.

Chairman THOMPSON. Thank you very much.

Chair recognizes the gentlelady from Michigan, Ms. Slotkin, for 5 minutes.

Ms. SLOTKIN. Thank you, Mr. Chairman, and thanks for the witnesses for being here.

My question is related to this supply chain issue. I am sure everyone on this screen went through the experience back in, you know, April, March, where were just desperately trying to get ahold of masks and gowns and gloves and very basic things. I remember very clearly being on the phone with Chinese middle-men in the middle of the night just trying to get some KN95 masks for our health care workers who were using things like scuba equipment in order to protect themselves as they intubated patients and whatnot.

Then I remember very clearly when we got our portion of the Strategic National Stockpile, it was a lot less than what we thought. We opened it up, it was moldy and expired. For us in Michigan I feel like we have been talking about how when you outsource supply chains, particularly on sensitive issues, on sensitive items, like it is going to come back to bite you, and I feel like it bit us.

So the question is we have the President at the White House today announcing a new kind of made-in-America supply chain review.

For Ms. Clowers, can you go through in specific terms what additional steps we need to take to if not bring back some of that supply chain to the United States, at least regionalize it so we are not dependent on countries we have sometimes a mixed relationship with, like China? What can the Defense Production Act and Buy American Requirements and the Government do to actually bring those supply chains home and make us less vulnerable?

Ms. CLOWERS. Yes. This is an issue that we have been tracking for about 9 months now because, as you note, it has been a persistent challenge from right at the beginning from the lack of supplies. What we saw was that domestically there was an insufficient amount of supplies on hand, or in some cases they were outdated, the supplies were unusable.

In terms of what can we do going forward, you know, we have called for a few things, including better clarifying the roles and responsibilities of all the different players. Again, we saw that confusion in terms of who was going to be providing what and how to get the supplies that were needed.

I should note that this isn't surprising, because in the fall of 2019 the Government conducted a pandemic exercise and through that exercise they found—some of the key findings was that we had

insufficient supplies and that we were going to have confusion and that it was going to lead to needed gaps.

In terms of going forward, so we have called for clarifying the roles, assessing what gaps exist now, but also looking ahead to try to get ahead of this a little bit, you know, 6–12 months, and also looking into the next pandemic. We do want to be looking at all the tools that are being used from the Defense Protection Act and other tools that we might be able to bring to bear in terms of financial incentives.

Two other quick points I will make on the financial incentives. Especially in the area of medical countermeasures, we have been—as we have noted, the vaccine development, we were successful this time in terms of getting a vaccine developed within a year, but that is an inherently risk process that is very costly. Most medical countermeasures actually fail. So we need to incentivize companies to work in this area, conduct the R&D necessary.

Then, finally, really examine the role of the Strategic National Stockpile. Is it to be a front line defense or a backstop? People need to have an understanding of what they can count on from this Strategic National Stockpile so State and local can plan.

Ms. SLOTKIN. Yes. I mean I think the truth is Democrats and Republicans all talk about this, right. It is like a really common message that people are saying after the year that we have lived through. But what I fail to see is actual action, right. We all know we have to look at gaps, we have to coordinate better. But what are we going to do actually incentivize that production to be made here? That is going to take breaking some china for how our system works.

Mr. Chairman, I would offer we could do maybe a bipartisan letter or something, particularly to DHS to talk about our concern about this and urge them forward so we get beyond this idea that we are all concerned and we actually start seeing changes in how the procure at places like DHS.

With that, I yield back the rest of my time.

Chairman THOMPSON. Well, staff will get with the gentlelady from Michigan and we will start drafting language for such a letter as you are talking about.

The Chair recognizes the gentlelady from Tennessee, Ms. Harshbarger.

Ms. HARSHBARGER. Thank you, Mr. Chairman.

I have several questions. The first is for Dr. Watson. I have been a pharmacist for 34 years and I absolutely understand the vaccination process and the manufacturing supply chain. You know, I was looking at the testimony from Ms. Clowers and what it says is that in nursing homes they did not capture for the first 4 months of the pandemic because they weren't required until May 2020.

My question to Dr. Watson is how important is accurate data collection as we continue to respond to this pandemic? The second part is how do we ensure that that data collection is consistent from State to State? What kind of parameters are in place to make sure that happens? Because this has to be data-driven. You know, there can't be any gaps in this.

Ms. WATSON. Thank you very much.

Yes, I completely agree with you. That should be a priority. As my colleagues have already stated, in order to make changes and to recognize where our response falls down, we need the data to drive that. So I think accurate data collection is very important. How we do that is in part having very consistent guidelines and guidance from the Federal Government, from the CDC in particular. That is really important to standardize how our data is collected.

Thank you.

Ms. HARSHBARGER. That is great.

I do agree with my colleague, Ms. Slotkin, because I have been talking for 25 years that we need to do something about the supply chain, us being able to have a domestic supply chain for finished pharmaceuticals as well chemicals to produce those domestically. You know, it is imperative we do that. Maybe it is about time, I don't know.

But, you know, what we did learn, and Mr. Norman touched on this, Warp Speed did provide us a vaccine in record time, and that really shows that these drug companies can get vaccines out from now on in a more timely fashion. It is not just that, it is other things as well. There is a lot of scrutiny when it comes to getting things to market.

But Congresswoman Jackson Lee asked you is our society sicker now than it was before and you said yes. Now, I have read in your testimony that the post-COVID syndrome, there are certain things that we have to worry about with that. I understand that that is things like loss of taste and smell, fatigue, that type of thing. I have read some articles that say that lasts 8.9 days and then 98 percent of people are cleared up within 28 days.

So in your testimony too, really 28 million reported cases of COVID what work is being done to understand those long-term effects of the virus? In my opinion, the long-term side effects are things like the school closures. You know, when are they going to do studies about what this detriment has done to the children in their learning capabilities. It put us back 10 years. You know, the closures are shuttering small businesses completely. These are things that I look at, but what are you doing—how are we going to study the long-term impacts of this virus?

Ms. WATSON. I think certainly we need to study all of the long-term impacts of this pandemic, and that includes societal impacts from the pandemic itself and from the efforts we have had to take to control it. But in terms of the long-term impacts of COVID and post-COVID syndrome, I know that there are a number of studies on-going. They are actually trying to understand what those effects are and how we can help people to recover more effectively from this virus.

But recent data has shown that many people months after they have recovered from the acute phase of COVID do have at least one of these symptoms and it is affecting their lives. So I think that is a really important thing that we need to look at.

Ms. HARSHBARGER. You also spoke about different variants of this COVID–19 virus. Do you know how many have been identified or how bad those strains are going to be? I was on another con-

ference call and they talked about those different strains. What have you learned about that and what should we know about that?

Ms. WATSON. I think we are trying to increase our surveillance across the country for these variants of concern. That is a really important effort that there is funding in the American Rescue Plan for additional surveillance capabilities. I think that is very critical.

Some of the variants are very concerning right now, particularly B117, which has been shown to be much more transmissible. We are watching that to see if that will cause another spike in cases in the spring. I am hopeful that it won't because we have mitigation measures in place. But there are other variants that also escape our response that we need to watch carefully and then plan our update to a vaccination in line with those.

Ms. HARSHBARGER. OK.

Chairman THOMPSON. The gentlelady's time has expired.

Ms. HARSHBARGER. I yield back.

Chairman THOMPSON. The Chair recognizes the gentleman from Missouri for 5 minutes, Mr. Cleaver.

Mr. CLEAVER. Thank you, Mr. Chairman. Thank you for having this hearing.

You know, one of the worst things that is going in this country, and I—you know, I have fear for my children and their children over the direction we are going. We try to politicize everything. It almost made me throw up to just hear the—you know, we have to politicize a pandemic. We politicize wearing masks, we politicize whether we drink bottled water or make a cup out of our hand, drink out of the faucet, drink out of a well. Whatever, it doesn't matter. We figured out how to politicize it and create some kind of a social battle on it. We have done it here. It just troubles me.

But what I would like a guest, those who are testifying, to help me understand, is that, you know, last March, the President said, you know, we want to be back in church by Easter. In my real life, last year was the first time I wasn't in church on Easter in my whole life. I am usually there 52 Sundays a year. Then he said it is going to be a great experience. I think when we start giving out false information it does damage.

My question to you is, is there a system that we need to put in place? Can you help me at least, figure out a way something we can put in place that will allow the Government, you know, to take a back seat because of the system we put in place? I know we are going to need the President's leadership on things like this, but maybe there is something I am overlooking. I have been trying to—now what could we have done to prevent what was done that has in fact probably cost us lives? Can any of you help me create this and get the Nobel Peace Prize?

Ms. CLOWERS. Well, sir, I would offer, you know, as we have looked back over the last year in terms of our work from lessons learned that have emerged—and actually these were lessons we also offered actually last February. I testified for a Senate panel as we were learning about COVID–19. Looking back through our work on H1N1, as well as responses to other public health emergencies, several things were clear about what we needed to be doing. I have mentioned some of them already, but we needed plans in place in terms of clarifying roles and responsibilities. Everyone needed to

know what they were responsible for and who they should be working with.

We needed clear and consistent communication in terms of messaging about where we were with the pandemic, what we were doing, and importantly, what steps we needed the public to take, because in a public health emergency you are asking the public to take certain steps. So you need to make sure that you are informing them in a clear and consistent way.

The same thing in terms of using data to drive decisions was another lesson learned. Making that data as readily available and understandable to the public so they understand why we are asking them to take certain measures. Then, finally with transparency and being as transparent with our actions as possible. So when the Government is making decisions, whether it is around testing guidance or improving emergency use authorization, the public understands and it can increase the confidence level in the actions that the Government is taking.

Mr. CLEAVER. Thank you. Thank you very much.

Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much.

Chair recognizes the gentleman from Georgia for 5 minutes, Mr. Clyde.

Mr. CLYDE. Thank you, Chairman Thompson.

I would like to take this opportunity to address my grave concern with the Biden administration's decision to eliminate the migrant protection protocols. This reckless decision will have the dual effect of putting Americans at risk of exposure to the coronavirus and creating conditions that mirror the 2019 border crisis. Increasing number of unaccompanied minors and families illegally crossing the border in the middle of a global pandemic is creating a recipe for disaster.

President Biden's Executive actions have the potential to cause mass outbreaks at facilities and ports of entry which would lead to their temporary closure that could have a significant impact on commerce and further handicap our economic recovery efforts. A mass outbreak would also jeopardize the health and safety of our men and women who serve on the front lines protecting our Nation's borders.

Finally, these Executive actions and a surge at the border have forced Customs and Border Patrol officials to return to the dangerous policy of catch-and-release. This policy releases migrants who have not been properly vetted or sufficient tested for coronavirus into our communities, putting the health and well-being of Americans at risk.

The Biden administration's actions are unacceptable and serve as distractions from what this committee should be focusing on, which is how we can secure our borders and prevent our constituents from being exposed to the COVID–19 virus.

I would like to submit for the record a letter that my colleagues and I on the House Oversight and Reform Committee send to Secretary Mayorkas highlighting these concerns. The letter is dated February 19.

With that, Mr. Chairman, I yield back my time.

Chairman THOMPSON. Thank you very much.

Without objection, the letter will be included in the record.
[The information follows:]

Submitted for the Record by Mr. Clyde

CAROLYN B. MALONEY, NEW YORK
CHAIRWOMAN

ONE HUNDRED SEVENTEENTH CONGRESS

JAMES COMER, KENTUCKY
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February 19, 2021

The Honorable Alejandro Mayorkas
U.S. Department of Homeland Security
Washington, D.C. 20528

Dear Secretary Mayorkas:

We write today to express our grave concern about the humanitarian crisis on the southern border, where unaccompanied alien children (UACs) and family units continue to arrive in extremely high numbers. The Biden Administration's policies limiting immigration enforcement and weakening border security, coupled with its proposal to grant amnesty to illegal immigrants, are signaling to the world that our immigration laws can be violated with little, if any, consequence. We are particularly concerned that the Biden Administration's actions could soon lead to a health crisis at the border and surrounding communities, causing widespread COVID-19 infections and fatalities.

The numbers of UACs and family units arriving at the southwest border decreased from its peak in Fiscal Year 2019 through Fiscal Year 2020.[1] This reduction is due to a combination of health and safety reforms implemented by the prior administration, including limiting gatherings of migrants in federal facilities through enrollments in the Migrant Protection Protocols (MPP) and the use of Title 42 expulsion authority, as advised by the scientists at the U.S. Centers for Disease Control and Prevention (CDC).[2] However, the U.S. Department of Homeland Security (DHS) halted enrollments in MPP immediately after President Biden took office,[3] and recent developments in Mexican law are causing difficulties in continuing to utilize Title 42 authorities with respect to family units. In addition to his reckless policies and executive actions, President Biden's rhetoric relating to amnesty for millions of illegal aliens and gutting

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[1] *Southwest Border Migration*, DEP'T. OF HOMELAND SECURITY, U.S. CUSTOMS AND BORDER PROTECTION, *available at* https://www.cbp.gov/newsroom/stats/sw-border-migration-YTDNovember#:~:text=In%20Fiscal%20Year%20(FY)%202021,entry%20on%20our%20Southwest%20Border (last accessed Feb. 5, 2021).

[2] *See Order Suspending the Right to Introduce Certain Persons from Countries Where a Quarantinable Communicable Disease Exists*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 13, 2020), *available at* https://www.cdc.gov/coronavirus/downloads/10.13.2020-CDC-Order-Prohibiting-Introduction-of-Persons-FINAL-ALL-CLEAR-encrypted.pdf

[3] DHS Statement on the Suspension of New Enrollments in the Migrant Protection Protocols Program (Jan. 20, 2021), *available at* https://www.dhs.gov/news/2021/01/20/dhs-statement-suspension-new-enrollments-migrant-protection-protocols-program.

interior enforcement priorities[4] is leading to a perfect storm on the southwest border. Without a radically different approach, a health, security, and humanitarian crisis is inevitable.

A November federal court injunction[5] prevented Title 42 expulsion authority from being utilized with respect to UACs, leading to a dramatic uptick in the number of UACs arriving at the southern border.[6] U.S. Customs and Border Protection (CBP) is currently facing over 1,500 apprehensions of UACs per week.[7] Though the injunction has been stayed,[8] the Biden Administration did not resume Title 42 expulsions of newly arrived UACs and instead carved out a temporary exception for UACs.[9] The administration has already announced the reopening of an influx facility at Carrizo Springs, Texas to deal with the increasing numbers of UACs.[10]

Developments in Mexican law have reduced the U.S. government's ability to expel some family units with younger children.[11] This has led to increased numbers of family units arriving at the southwest border.[12] To prevent overcrowding and ensure children do not spend more than 72 hours in custody, border personnel are forced to quickly process those family units under Title 8, issue them Notices to Appear in immigration court, and release them into the interior without any quarantine or COVID-19 testing.[13]

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[4] *See* Memorandum from Acting Secretary David Pekoske to Troy Miller, et. al., *Review of and Interim Revision to Civil Immigration Enforcement and Removal Policies and Priorities* (Jan. 20, 2021), *available at* https://www.dhs.gov/sites/default/files/publications/21_0120_enforcement-memo_signed.pdf

[5] *P.J.E.S. v. Wolf*, No. 20-2245 (D.D.C. Nov. 18, 2020), *available at* https://www.aclu.org/legal-document/ruling-pjes-v-wolf.

[6] *See* Email from Dana L. Vander Veen, Congressional Liaison Specialist, U.S. Customs and Border Protection to Congressional Staff, January 22, 2020, *on file with committee staff*. ("It is notable that UAC encounters have more than doubled over the past two weeks to levels that exceed those experienced prior to the holidays.")

[7] *See* Email from Dana L. Vander Veen, Congressional Liaison Specialist, U.S. Customs and Border Protection to Congressional Staff, February 2, 2020, *on file with committee staff*. (1644 UAC's booked out between 1/17/2021 and 1/23/2021).

[8] *See* Order Granting Motion for Stay Pending Appeal, *P.J.E.S. v. Pekoske*, 20-5357 (D.C. Cir. Jan. 29, 2021) *available at* https://www.aclu.org/legal-document/dc-appeals-court-stay-order.

[9] *See Notice of Temporary Exception from Expulsion of Unaccompanied Noncitizen Children Encountered in the United States Pending Forthcoming Public Health Determination*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 11, 2020), *available at* https://www.cdc.gov/coronavirus/2019-ncov/more/pdf/CDCPauseNotice-ExceptfromExpulsion.pdf

[10] Knight, Stef W., *Biden's brewing child migrant crisis*, AXIOS NEWS (Feb. 2, 2021), *available at* https://www.axios.com/border-migrant-child-crisis-biden-coronavirus-8bce4ec4-a881-4974-abdb-404c39b1030f.html.

[11] La Jeunesse, William, *Biden administration's CBP revives 'catch and release' policy at border amid COVID concerns*, FOX NEWS (Feb. 5, 2021) *available at* https://www.foxnews.com/politics/biden-administrations-cbp-revives-catch-and-release-policy-at-border-amid-covid-concerns.

[12] *See* Email from Dana L. Vander Veen, Congressional Liaison Specialist, U.S. Customs and Border Protection to Congressional Staff, February 9, 2020, *on file with committee staff*. ("We wish to draw your attention to the dramatic increase in family unit apprehensions – more than quadrupling in just the past two weeks.").

[13] La Jeunesse, William, *Biden administration's CBP revives 'catch and release' policy at border amid COVID concerns*, FOX NEWS (Feb. 5, 2021) *available at* https://www.foxnews.com/politics/biden-administrations-cbp-revives-catch-and-release-policy-at-border-amid-covid-concerns.

The increasing number of UACs and family units illegally crossing the border will soon overwhelm border facilities in the middle of a global pandemic, forcing CBP officials to resort to widespread, rapid catch and release of unlawfully present individuals and families into the interior of the country. This surge also has the capability to cause a COVID-19 outbreak at ports of entry and other CBP facilities, which threatens the health of CBP personnel and could result in the temporary closures of ports of entry. Such closures would greatly impact commerce and hamper the United States' economic recovery. The increase in illegal immigration at the southern border presents a risk not only to Border Patrol agents apprehending migrants who illegally cross the border, but also to those communities into which those individuals will relocate—likely leading to widespread COVID-19 infection and fatalities.

To assist us in understanding the administration's plan to prevent the impending catastrophe on the border, please provide documents, communications, and information sufficient to answer the following questions no later than March 5, 2021:

1. What is the administration's plan, if any, to reduce illegal border crossings by UACs and Family Units (FAMU) along the southwest border?

2. What is the administration doing to prevent the spread of COVID-19 in custodial facilities along the southwest border, to protect CBP personnel from exposure to COVID-19, and to prevent the introduction of COVID-19 into border communities and the interior of the United States upon release of an alien from CBP custody?

3. Please provide statistics on apprehensions of illegal border crossers on the southwest border for the period of October 1, 2020 through the present, disaggregated by whether the individual apprehended was designated as a UAC, FAMU, or single adult, as well as the various countries of origin and case disposition.

4. What steps, if any, are being taken by U.S. Immigration and Customs Enforcement to increase bedspace capacity at Family Residential Centers to ensure that family units are held in custody together throughout any immigration proceedings instead of being released into the interior of the country?

5. What steps, if any, are being taken to expedite immigration proceedings for UACs and family units that cross the border illegally, and does the DHS intend to prioritize the removal of those UACs and family units who are ultimately ordered removed?

6. What steps, if any, is the administration taking to address this crisis with the Mexican government, including whether the administration has asked the Mexican government to continue facilitating Title 42 expulsions?

Thank you for your consideration of this important issue. To make arrangements to deliver documents or ask any related follow-up questions, please contact Committee on Oversight and Reform Republican Staff at (202) 225-5074.The Committee on Oversight and Reform is the principal oversight committee of the U.S. House of Representatives and has broad authority to investigate "any matter" at "any time" under House Rule X. Thank you in advance for your cooperation with this inquiry.

Sincerely,

James Comer
Ranking Member
Committee on Oversight and Reform

Jody Hice
Ranking Member
Subcommittee on Government Operations

Glenn S. Grothman
Ranking Member
Subcommittee on National Security

Michael Cloud
Ranking Member
Subcommittee on Economic and Consumer Policy

Ralph Norman
Ranking Member
Subcommittee on Environment

Pete Sessions
Ranking Member
Subcommittee on Civil Rights and Civil Liberties

Jim Jordan
Member of Congress

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Bob Gibbs
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Clay Higgins
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Fred Keller
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Andy Biggs
Member of Congress

Andrew S. Clyde
Member of Congress

Nancy Mace
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Scott Franklin
Member of Congress

Jake LaTurner
Member of Congress

Pat Fallon
Member of Congress

Yvette Herrell
Member of Congress

cc: The Honorable Gerald E. Connolly, Chairman
Subcommittee on Government Operations

The Honorable Stephen F. Lynch, Chairman
Subcommittee on National Security

The Honorable Raja Krishnamoorthi, Chairman
Subcommittee on Economic and Consumer Policy

The Honorable Ro Khanna
Subcommittee on Environment

The Honorable Jamie Raskin, Chairman
Subcommittee on Civil Rights and Civil Liberties

Chairman THOMPSON. Chair recognizes the gentleman from Texas for 5 minutes, Mr. Green.

Mr. GREEN. Thank you very much, Mr. Chairman. I am honored to have this opportunity to ask questions.

Let me lay the predicate. President Trump led three-quarters of the 69 press events during the first 13 weeks of the pandemic.

First question, how important it is it for the professionals to give professional advice at the inception of a pandemic, in its nascency? Dr. Watson, would you kindly respond?

Ms. WATSON. Yes, sir. The professionals, the public health experts, the scientific experts need to be able to provide their expert judgment on the pandemic situation. It is not always totally clear-cut what the situation is, but they need to be able to weigh in with their experience and education and their related judgment. When

they are prevented from doing that or when political pressures are put on them to say something that contradicts that experience and that judgment, that is where we run into trouble.

Mr. GREEN. I think it is fair to say that—and I mean no disrespect—but that some of the advice that was given by the President, some of that advice proved to be harmful to some members of the public. I can recall persons taking certain chemicals to their bodies that were harmful to them.

Is this the kind of thing that you can avoid if you allow the professionals to lead?

Ms. WATSON. Yes, sir. Good risk communication will tell people what they can expect in terms of risk, what actions they should take to protect themselves, and answer the questions they have, but won't lead them to do things that are more dangerous.

Mr. GREEN. Now, on the other hand, juxtaposing the Biden administration to the previous administration, we have the Biden administration with a commitment to put shots in arms. In fact, in my Congressional district, the Biden administration is setting up a super site, 6,000 shots in arms per day, to have a total of 126,000 people vaccinated. This is coming from the Federal Government in concert with the State, the county government, and the city. This is a collaborative effort.

Is this the kind of effort that you need in a pandemic so as to thwart the pandemic as quickly as possible?

Ms. WATSON. My colleagues and I like to say that the pandemic breaks systems. So what we need is people to come together at all levels of government to address this unprecedented challenge. Yes, that is the type of coordination that we need.

Thank you.

Mr. GREEN. Finally, minority communities are especially vulnerable—a multiplicity of reasons why, but it appears to me that we have to do more in terms of assuring minority communities that they will get the vaccine. But, on the other hand, we also have to assure minority communities that this vaccine is going to be safe. There are good reasons for minority communities to have consternation about injecting vaccines into their arms given the history that they have suffered in this country.

What would you say to the minority community in my city that may be watching now? Because of certain circumstances that have occurred, what would you say them to encourage them to please get these vaccinations?

Ms. WATSON. I would say that I understand that there is a history of abuses that have made it difficult to trust both Government and health care systems, but I would encourage individuals in your community to listen to their local leaders, to try and understand the facts about the vaccine in particular and to judge for themselves how safe and effective it is.

I hope that that will give them the information they need to make a good decision.

Mr. GREEN. Thank you, Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The gentleman yields back.

The Chair recognizes the gentleman from Florida, Mr. Gimenez, for 5 minutes.

Mr. GIMENEZ. Thank you, Mr. Chairman. I appreciate it. Dr. Watson, a couple of questions for you. You state in your testimony that certain countries were very effectively keeping the virus out. What are those countries? Which countries were they?

Ms. WATSON. There are a number, but the ones that I have in mind are particularly New Zealand and Australia right now. Those are the ones that I have kind-of held at the top of mind, yes.

Mr. GIMENEZ. What do you account that? How do you account for that? Why were they able to keep it up?

Ms. WATSON. Yes, there were a number of factors early on. They took very quick action to prevent cases from coming in, to identify cases early, and then to take the public health actions to prevent those cases from turning into epidemics by finding every case as much as possible. Then doing contact tracing and ensuring that the transmission didn't continue.

Mr. GIMENEZ. They were able to return to basically a normal kind of existence, normal kind of life in those countries?

Ms. WATSON. Yes. In some cases, the life looks—has looked pretty normal over the last several months. With the exception of if there is an introduction of a case, then those countries often take pretty rapid action to shut things down to prevent epidemics, but then they are able to return again to more normalcy.

Mr. GIMENEZ. Are they open to the world or are they shut off from the rest of the world?

Ms. WATSON. I don't know. I don't have the facts fully on that, but I think mostly that things have slowed like with the rest of the world. Transportation has slowed and so, it looks largely like the rest of the world in that way.

Mr. GIMENEZ. Do you know if we test the migrants coming on the Southern Border, do we test them for COVID–19?

Ms. WATSON. Like my colleague, I don't have that information, but I am happy to get back to you on that.

Mr. GIMENEZ. Does anybody on this call have that information? OK. Also, do you know if we are testing,—I guess nobody has the answer to that—if there is a different variant that they are bringing in from the south? Because I understand that the Brazilian—the Brazilian variant of COVID–19 is very similar to the South African variant, which is resistive to the vaccine?

Ms. WATSON. I think that the data on that is still a little unclear about the P.1 variant. But what we do know is that these variants are already here in the United States, and they have been identified in many States already.

Mr. GIMENEZ. OK. I think final question is do we know the percentage of Americans that are refusing to get vaccinated?

Ms. WATSON. I am not up on the current number on that. I think there have been some significant polling, but I am not sure what the most recent number is.

Mr. GIMENEZ. What number would that be that would make the vaccination—the vaccination program less effective, let's say, to getting back to a normal life?

Ms. WATSON. I think we need to aim for a high number of vaccinations around the country. In our very vulnerable populations, we should aim very high in the 80th, 80 percent range. In the general population, it is hard to pinpoint an exact number, but I think

we need to reach at least 60 percent of people vaccinated. That should be our goal. But there is no hard and fast number to say that it will be a success or a failure.

Mr. GIMENEZ. OK. Do we have—again I know that I heard somewhere else, I guess, in another hearing that there is a variant. The variant from South Africa is resistive to the—is resistive to the vaccine, but if you do get vaccinated and you get sick with that variant, that you won't die and it will be a much milder effect. Have you heard that also? Have you heard also that?

Ms. WATSON. The data we have seen so far shows that vaccines have been highly protective against hospitalization and death against many of these variants. So, that is a hopeful sign.

Mr. GIMENEZ. Is there any variant that you are afraid of?

Ms. WATSON. I am afraid of those variants that escape our immune responses, whether it is natural immunity or vaccination. So, I think we need to track them very carefully and we need to plan for the future of the pandemic in this country. We may need to update our vaccines to respond to these threats.

Mr. GIMENEZ. OK. Thank you very much. I appreciate it. I yield back my time.

Chairman THOMPSON. Thank you. The gentleman yields back. The Chair recognizes the gentlelady from New York for 5 minutes, Ms. Clarke.

Ms. CLARKE. I thank you, Mr. Chairman. I thank our Ranking Member. Approximately 1 year ago, life as we knew it came to a screeching halt. Within that year, COVID–19 has claimed more than half a million lives. This many deaths did not have to happen. For decades to come, we will look back at the previous administration's handling of this crisis as a textbook case study of how not to handle a pandemic. Fortunately, President Biden has made it clear that going forward, we will let science, not politics, guide our response. I happen to represent a district that has been particularly hard hit by COVID–19 as part of the epicenter of the outbreak of the pandemic. We all know that communities of color have borne the brunt of the pandemic. Brooklyn is one of those areas. It is also home to countless essential workers, many of whom are immigrants. They are the heroic front line, the lifeline, and most vulnerable, all at the same time in this pandemic. They are a significantly crucial segment of the population of our communities in New York City who have faced some of the highest infection rates in the Nation.

We must rapidly address the inequities in public health and eliminate the disparities from our COVID–19 response. Having said that, I want to turn your attention to Project Airbridge. I have to tell you, living in New York when we had to scramble, outbid, and do everything we could without the help of the Trump administration because the States were handling it. Project Airbridge to see Robert Kraft's airplane land at JFK with a New England Patriots sign on it and not a B–59, or whatever the plane is from our National Guard or our military, was such a slap in the face to Americans.

Over the past year, when it came to securing PPE for front-line medical workers, I certainly know why New York had significant struggles. The Trump administration repeatedly touted Project

Airbridge as a success story in accelerating the importation of critical PPE. FEMA indicated that at least 50 percent of its supplies were directed to hot spot areas. But there was a serious lack of transparency to confirm this occurred. As a matter of fact, it looked like a rewarding of some friends, i.e., New England Patriots.

Despite repeated requests, we never received information on where the supplies went and other basic details. I raised this at the committee's July 14 hearing. Dr. Ezike, when it comes to securing PPE, could you share with us your thoughts on how States were forced to compete to secure PPE and what Governor Pritzker told the committee was akin to the Hunger Games and the degree to which Project Airbridge was effective in meeting Illinois' supply needs?

Dr. EZIKE. Yes, thank you, Congresswoman. Significant challenges in the securing of PPE, as I think another representative who was in the struggle last year, we were talking to middle men in various countries, in China, you know, I got a guy, I got a guy.

Ms. CLARKE. Mm-hmm.

Dr. EZIKE. We were sometimes outbidding trying to bid or outbid other States. In one situation where we did have an arrangement to have a large shipment, we then got outbid. Our order was canceled as the Federal Government was outcompeting us. We had to at one point, actually take State police to the airport to make sure that there wouldn't be any interception——

Ms. CLARKE. Mm-hmm.

Dr. EZIKE [continuing]. Of a shipment that was coming in. So, very uncharacteristic moves were undertaken to secure this lifesaving PPE for the pandemic.

Ms. CLARKE. I thank you, Dr. Ezike. Let me just say that that was a disgrace. We need to really unpack what happened with Airbridge and make sure it never happens again. With that, Mr. Chairman, I yield back the balance of my time.

Chairman THOMPSON. Thank you very much. The gentlelady yields back. The Chair recognizes the gentlelady from Iowa, Ms. Miller-Meeks, for 5 minutes.

Ms. MILLER-MEEKS. Thank you very much. I was trying to unmute myself. I appreciate it, Chair. If I could, I have a couple of very quick questions and then a more lengthy question. So, Mr. McMahon, you mentioned the local public health and local public health funding. Both as a physician and the former director of the Iowa Department of Public Health, I am wondering—and this is one of the things I advocate for—is that rather than money that is allocated to the States and then the State decides, could there not be funding go directly to CDC and then go to local public health grants, which would then go to our local public health agencies? Would that not be a pathway——

Mr. MCMAHON. Yes.

Ms. MILLER-MEEKS [continuing]. For us to get funding to local public health agencies so they both have adequate PPE and can vaccinate?

Mr. MCMAHON. Yes, I think any time if the intention is to get us the funding, finding a way to get us directly, guarantees you get us the funding. We have great relationships with our State part-

ners. But certainly, there are times where funding goes to the States and it doesn't flow back to the local governments.

Ms. MILLER-MEEKS. Yes, I had that same conversation with my local public health agencies. Then, Dr. Ezike, can you—do you know what the number of non-COVID-related excess deaths are in the United States due to the pandemic? I ask that because in San Francisco published in January of this year—I have referred to this pandemic as life versus life. In January this year, *San Francisco Chronicle* published that there were 699 deaths from overdose. It would have been much more than that had it not been for dispensation of Narcan. This was 57 percent greater than in 2019. So, vastly outstripping. The number of COVID deaths in San Francisco at that time were 121. So, do you know the number of non-COVID-related excess deaths in the United States during the past year?

Dr. EZIKE. Doctor, we have that number. I don't have it at my fingertips, but our team can get that back to you. But I think we had at least, it was at least 20 or 30 percent on top of the known COVID deaths. So, we would say that those may have been some missed COVID deaths as well as other non-COVID deaths within that number.

Ms. MILLER-MEEKS. Yes, so, over the summer I had found a figure of approaching 98,000 at the end of summer. My next question and this can be to Ms. Clowers or any of the panel members. But, again, as a physician and former director of the Iowa Department of Public Health, one of the most concerning things to me at the start of the COVID–19 pandemic, was the issues of our country had with supply chain of pharmaceuticals and PPE. Given my time in the military, the supply chain is very concerning to me. In particular, I was concerned about our country's ability itself to produce medical supplies domestically.

As you know, last spring the Chinese Communist Party issued threats to cut off the supply of medicine to the United States just as the virus was beginning to spread widely in our country. Thankfully, the Chinese Communist Party did not act on that threat. But it exposed the vulnerability of our medical supply chain when we rely on foreign countries and foreign nations for these critical supplies. Some of the supplies that some countries received were inadequate or deficient.

So, Ms. Clowers, in your testimony you discussed several recommendations for addressing supply chain challenges. I appreciate those recommendations. What I am asking is that what lessons can we apply to further pandemic preparedness efforts? Are there steps that we as a Nation can take to ensure that we have critical medical supplies that are available domestically, rather than enacting the Defense Production Act to get those supplies produced here?

Ms. CLOWERS. Yes, in addition to the recommendations that you mentioned, we do need to go back and look at our domestic supply chain as a Nation in terms of how we can make it more robust. Because what the pandemic illustrated when it started, we had inadequate supply of supplies on hand. The supply chain is made up of a number of players and a number of entities. So, we need to have a better understanding of what everyone has and what their capabilities are. Including in that is the Strategic National Stockpile.

Ms. MILLER-MEEKS. Right.

Ms. CLOWERS. Understanding what is the role that that is going to play and how we would stock that stockpile and how we are going to manage it. Those are important policy decisions for the Congress to consider. You also mentioned in terms of the supply chain that also we often think about PPE right now, but it is the drugs too. Most of our generic drugs are manufactured overseas, particularly in China and India. That creates a vulnerability for us as a Nation as well.

Ms. MILLER-MEEKS. Thank you so much. Both drugs, PPE, and pharmaceuticals in the Strategic National Stockpile. Thank you so much. I yield back my time, Mr. Chair.

Chairman THOMPSON. Thank you very much. The gentlelady yields back. The Chair recognizes the gentleman from California, Mr. Swalwell, for 5 minutes.

Mr. SWALWELL. Thank you, Chairman. Thank you to the panelists. Many of us gathered last evening on the Capitol steps, House Members and Senators. We remembered the 500,000 COVID victims that we have lost. As sad as it was to do that, a lingering thought I had was will we be back here shortly to remember 1 million lost? I think what we do as leaders on this committee and with our neighbors and people in the community will determine that.

I want to turn to Dr. Watson and ask you a question, Dr. Watson, about misinformation. Because what we learn and how we act on that certainly will dictate future loss. We have seen harmless misinformation like mouthwash can stop COVID. We have seen harmful misinformation like ingesting bleach or disinfectants can stop COVID. We have seen reports of people showing up at emergency rooms because they have done this. So, what can we do to combat what is called infodemic? How deadly is infodemic to our ability to take this on?

Ms. WATSON. Thank you for that question. We have seen that misinformation, I think, on balance has had a very significant impact on public health and in the pandemic. As you mentioned from people taking treatments that are unsupported by science to not believing in the virus itself up until the point of death in some cases. So, I think this is a large factor in shaping how the pandemic evolved in this country.

The WHO has proposed a research and policy agenda for combating misinformation, which really includes a combination of limiting its prevalence on-line and improving the reach of high-quality information that is health protective. But more research is needed into how we can effectively manage this. I also think that the United States needs a plan to combat mis- and disinformation especially as it relates to health.

Mr. SWALWELL. Thank you, Dr. Watson. Also, on the topic of communication, the National Biodefense Strategy lays out the importance of coordination between the Federal and State and local governments while responding to a pandemic like COVID–19. Last year, Governors reported that they had limited information from the Federal Government about when vaccines would become available. They only would learn a week ahead of time as to the number of vaccines they would receive, leaving many States scrambling to implement distribution strategies.

President Biden has sought to increase coordination and communication with the States, especially to get the vaccine and numbers up earlier than just a week out. So, what other steps can the Federal Government do to coordinate with State and local governments? I will open this one up to any panelist.

Dr. EZIKE. This is from the Illinois response. We can say that we have really enjoyed in the last month communication, and if there is such a thing as overcommunication, from the COVID response team with this new administration. We are very grateful for the 3-week lead time in terms of allocations, which allows for appropriate planning at the State level and, of course, for our local partners who can determine the numbers of vaccine appointments that can be made based on knowing 3-week allocations.

We are really grateful to hear their priorities and then their plans for supporting us in implementing those National strategies and priorities. So, we are really grateful for on-going communication and we see that as an important measure to getting on the other side of the pandemic. We have also seen responsiveness to issues from the boots on the ground. So, as we share concerns, those are taken back, acted on, and then brought back and collaborative decisions are made.

Mr. SWALWELL. Great. Thank you to the panelists. Thank you to the Chairman, and I yield back.

Chairman THOMPSON. Thank you very much. The gentleman yields back. The Chair recognizes the gentlelady from—the gentleman from Kansas, Mr. LaTurner, for 5 minutes.

Mr. LATURNER. Thank you, Mr. Chairman, and thank you to Ranking Member Katko, and to all the panelists. Mr. McMahon, in your written testimony, you addressed Syracuse University's opening in August. You talk about testing and as we know, the science tells us that college-age students are more susceptible to the coronavirus. They will spread it more easily than elementary students will. So, talk a little bit about that process.

Mr. MCMAHON. Yes, and so, essentially the testing—the testing before the student actually comes into the community was done. Then when they got literally physically on campus, we tested them again. Then Syracuse University is doing a tremendous job implementing what is now-weekly testing. They have actually even invested into their own lab on campus so that they can meet the State restrictions related to positivity rates now. Before they were being held to a 2-week period of time, where to remain in-person learning, they could only have 100 cases on a campus of 15,000 students. It is a pretty tough threshold.

So, testing has been the key to our success in central New York related to our positivity rate. It has allowed us to rebalance the public health decisions we are making related to whether it is in-person learning for our pre-K–12, or certainly, our higher ed as well.

Mr. LATURNER. Just to be clear, this is months before a vaccine that Syracuse was able to open. Tell me this, did they—you mention testing—did they have to spend millions of dollars upgrading ventilation systems or reconstructing spaces to accommodate social distancing?

Mr. MCMAHON. They did. They spent money, obviously, on the testing infrastructure, right? That is a business decision the university makes to get their students back on campus. Certainly, they did look at updating and investing in ventilation systems, distancing, mask wearing. They were very strict related to, as we all know, the college experience brings different social aspects to it. We would have hiccups where you would have parties that would lead to cases. The university responded and responded quickly.

But because of that and the management of that, to your point before the vaccine was ready, and again, at this point, students aren't even eligible to get the vaccine in this process now. We have had the spring semester has started and things are going quite well. The positive rate if they were their own State at Syracuse University's campus, they would be the best State in the country with the positive rate that they have.

Mr. LATURNER. Thank you very much. Thank you, Mr. Chairman. I yield back my time.

Chairman THOMPSON. Thank you very much. The gentleman yields back. The Chair recognizes the gentlelady from Nevada, Ms. Titus, for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman. Thank you for holding this hearing. You know, we have heard a lot from some Members across the aisle about the folks who are at the border and the immigrants at the border. But we haven't really heard much discussion about the 11 million undocumented people who are already in this country. So, I would like to ask the panel, and maybe starting with Dr. Ezike, how the policies of the former President, including the public charge rule, have affected the undocumented community in terms of getting the virus, getting good information, dealing—I mean, getting the vaccine, getting good information, and dealing with the virus. You know, so many are distrustful of Government. They are fearful of being deported. They are worried that it will harm their chances of gaining permanent status.

So, if you all could discuss how it has been a problem, how we can address it, how it makes it more difficult to deal with the broader community if you have a large segment like in my district of folks who aren't vaccinated or aren't willing to kind-of put themselves out there to get the information or get the shot in the arm.

Dr. EZIKE. Thank you for that question. So, as I started in my opening remarks, we understand that no one is safe if everyone isn't safe. When we have individuals living in our communities who have the virus, the virus doesn't care what color your passport is. It will spread to any individuals around. So, understanding that everyone needs to be tested, needs to be vaccinated, is the only way that the whole community will be able to move forward.

We have heard on virtual town halls and community meetings that there is a hesitancy to come forward for fear of being reported, for fear of having information being turned over. So, we just understand that all of these individuals who form the fabric of our communities who care for children, who work in essential roles that are often engaging with the public in high numbers, they will go on to infect other people if, you know, if the infections and the infection transmission is not contained by either aggressive testing and/or vaccination. So, again, we just have to understand the ba-

sics of infectious disease spread that we have to control the spread by testing, contact tracing, and vaccination. We have to take care of all of the people in our midst to get beyond to the other side of the pandemic.

Ms. TITUS. Anybody else want to address that? Well, what you say, Doctor, is certainly true in my district because a lot of these folks work back of the house in gaming, back of the house in restaurants. They are in service positions where they could be spreading the virus.

Also, we have the problem of multi-status families. In one family, one person is a citizen, one person is a dreamer, one person is on TPS, one person doesn't even know what they are, you know. So, if one person is afraid to come forward, then you have got a whole family that will be affected.

Well, I think we need to figure out how to do a better job of getting information, not just into minority communities, but into these undocumented communities to try to reassure people and get the best health and science information to them to make them realize this is something in their own interest and not something that is going to come back to bite them like public charge.

Dr. EZIKE. Yes, ma'am. We have been trying to message directly in the native language in Spanish. Making documents available in Spanish and working with community-based organizations that already have a leg in those communities to make sure that they have trusted messengers telling them that it is OK, that there is no charge, that they should take advantage of testing and vaccination.

Ms. TITUS. Well, thank you. Thank you, Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The gentlelady yields back. The Chair recognizes the gentleman from New Jersey, Mr. Van Drew, for 5 minutes.

Mr. VAN DREW. Thank you, Chairman Thompson and Ranking Member Katko. The coronavirus pandemic has had a devastating impact on our Nation with over 27 million confirmed cases and half a million deaths in the United States alone. This is a tragedy. In addition to the high death toll, our economy has suffered due to oppressive lockdowns, which have exacerbated the hardship experienced by so many people. States and cities across our Nation have seen record unemployment numbers. Atlantic City, New Jersey one of the most populous cities in my district, had the Nation's highest unemployment rate, 34 percent, last summer.

Not allowing people to safety and responsibly resume work is not the answer. Restaurants, gyms, and other essential businesses and industries have been decimated by the coronavirus. My district's economy heavily relies on summer tourism. Those summer months are what drive the regionals' economic success. But because of restrictive lockdowns, many businesses had to permanently close their doors forcing thousands of people out of work.

Fortunately, there is light at the end of the tunnel. Thanks to the previous administration's steadfast initiatives like Operation Warp Speed, we now have multiple vaccines that are being distributed and administered every minute of the day.

We must continue to focus on how we can safely reopen businesses and our schools and continue to get America vaccinated.

America needs to get moving again. I look forward to that with my colleagues on the committee on how we, on how we can best facilitate moving forward again.

I have a couple of questions for Nicole. For Nicole Clowers, what changes to regulations pertaining to the Strategic National Stockpile should be changed to ensure that we are better prepared for future disease outbreaks?

Ms. CLOWERS. Well, one of the things that—first, thank you for the question. One of the things we have called for is as the administration continues to reexamine the supply chain, which is an effort that is on-going, that they include the Strategic National Stockpile. Because what the pandemic has demonstrated is there is not a good understanding of the role that it plays in terms of should it be the sort-of front-line defense? Or is it more of a backstop? What type of supplies should be in it? Should it be for high probability, but low consequence? Or the reverse? These are the discussions that need to happen. What we have encouraged is for the administration to reach out to the Congress, as well as non-Federal stakeholders to have this conversation to make those decisions, because it affects multiple players in all levels of the government.

Mr. VAN DREW. Thank you. For Crystal Watson, how do we ensure that the data collection is consistent from State to State?

Ms. WATSON. I think that the best way to ensure that is to provide consistent Federal guidance to States about how and what data they should be collecting. Then giving them support to do that data collection.

Mr. VAN DREW. Are we working in that direction?

Ms. WATSON. I believe that CDC is working in that direction, yes.

Mr. VAN DREW. OK. So, your sense is that we are improving in that area from what you know and understand of it.

Ms. WATSON. Yes, sir.

Mr. VAN DREW. OK, thank you. Mr. Chairman, I yield back.

Chairman THOMPSON. The gentleman yields back. The Chair recognizes the gentlelady from New Jersey also, Ms. Watson Coleman.

Ms. WATSON COLEMAN. Thank you, Mr. Chairman. Thank you for this briefing to each of those who have participated here. I have got a quick question for Ms. Clowers. It is my understanding that the Biden administration is trying to track down this so-called 20 million doses of vaccine that were released by the Trump administration, however, no one knows where it is or who received it. Do you have any information on this?

Ms. CLOWERS. We are looking at these issues as well. We have on-going work looking at vaccine distribution. What we are finding is there has been miscommunication about the number of doses that were available and delivered and allocated. It is a issue that the administration is working on now to try to improve the data. Certainly, we have heard from the National Governors as well about concerns about the reporting of the data and the doses that are coming to them, as well as the number of shots that are being given. So, I think it is a communication issue as well as a data issue. But we have on-going work and are looking at that, and we will be happy to brief you——

Ms. WATSON COLEMAN. Thank you.

Ms. CLOWERS [continuing]. When we have our report.

Ms. WATSON COLEMAN. Appreciate that. With all due respect, I think that there is an honesty, lack of transparency, incompetence issue that was at play in this former administration. Had we had more honesty, transparency, a recognition respect of the science, as well as competence, we wouldn't have to have this briefing today at this level.

This question is for Dr. Ezike and Dr. Watson. Although there is a big focus on vaccines these days, it is important to remember what other mitigation measures like wearing a mask are proving to work. Over the past year, instead of setting an example for the country by wearing a mask, President Trump downplayed the virus and even mocked wearing masks for months. In fact, Trump berated Biden for wearing a mask. Even after contracting the virus himself, hosted campaign events which were subsequently considered super spreaders. Dr. Ezike and Dr. Watson, do you believe having our elected officials act as leaders and promote science-based mitigation measures is important in fighting this COVID–19? If this were done since the beginning of the knowledge of the pandemic, would we not have saved more lives?

Dr. EZIKE. Thank you for that question. We have seen that the example of our leaders carries significant clout. We have individuals that decide to vaccinate or not based on people that they trust getting vaccinated. Likewise, we had people turn against masking because there was a culture of anti-masking or that masking wasn't necessary. So, absolutely, that is important.

Ms. WATSON COLEMAN. Thank you. Dr. Ezike, did you experience any problems with constituents in your State thinking that it would be safe to ingest bleach and other chemicals as a way of preventing the virus? If so, to what extent was that an issue for you?

Dr. EZIKE. Yes, ma'am. We did have several reports to our poison control center of individuals that were asking about the dangers associated with ingesting bleach after that—after that announcement.

Ms. WATSON COLEMAN. Thank you. Dr. Watson, do you have anything to add to this?

Ms. WATSON. I agree with my colleague, Dr. Ezike. I think there is no substitute for effective leadership in this type of a crisis. So, I think it is critically important.

Ms. WATSON COLEMAN. Do you agree that had we had that leadership or response in a timely manner when we first encountered the knowledge of this virus that we would not have the severe loss of life and infectious rate that we have in this country?

Ms. WATSON. I think that improved leadership and better communication would definitely have saved lives and I think people have died unnecessarily in this pandemic, certainly.

Ms. WATSON COLEMAN. Thank you to all 3 of you. Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The gentlelady yields back. The Chair recognizes the gentleman from Michigan, Mr. Meijer, for 5 minutes.

Mr. MEIJER. Thank you, Chairman Thompson, and Ranking Member Katko, and to our guests who are here today. I want to

circle back to a topic that both my colleagues, Representative Mariannette Miller-Meeks and Representative Slotkin mentioned around PPE and, specifically, domestic production and how that factors into not only the Strategic National Stockpile, also State-level stockpiles.

I guess, I first want to start with Dr. Ezike. Can you, I guess, from your vantage point and your experience at the Illinois Department of Public Health, you know, thinking not just in the moment we are in right now, but once now that we have a little bit more light at the end of the tunnel, and we have the Johnson & Johnson emergency use authorization out, what can the Federal Government do to best provide States with the resources, with the guidance necessary so that those State-level stockpiles cannot only be built back, but also adequately maintained so we don't experience the out-of-date or expired material issues that we saw on both the State-level stockpiles and the Strategic National Stockpile?

Dr. EZIKE. Yes, thank you for that question. So, I think it might be helpful just to establish National benchmarks. National benchmark in terms of levels that would be considered adequate. We had to dispense PPE not only to our 97 different local health departments, but also first responders, and also, long-term care facilities. I mean, the needs and the requests came from every direction. So, being able to have established benchmarks and protocols in terms of numbers and levels of storage, being able to have back-up at the Strategic National Stockpile, being able to have plans in terms of when those products would be able to be reviewed that with ongoing frequency, we would be able to determine whether things that had reached their expiration date could still be tested and still be determined to be effective for use versus needing to be removed. That kind of organization might be very helpful for, unfortunately, the next pandemic.

Mr. MEIJER. Doctor, just kind-of building on that. I know, you know, the analogy in a home especially if might be approaching a—or just from a disaster preparedness standpoint, is every product in your home has a shelf life, right? So, you get a little bit more than you need, you know, put the newest in the back. Take the oldest from the front. You know, do you think it is feasible to have a similar sort of paradigm at the State stockpile level where it is not just, you know, we have a mass purchase and we leave it there to sit. Then after a certain point, it expires, we have to throw it out and buy more. But have more of an evolving stockpile where hospitals aren't just relying on that sort-of just-in-time delivery, but there is that kind of deeper batch in material as well?

Dr. EZIKE. No, eventually that would the goal that we would get to. But as we think about replenishing all our stock now, everything that we would get now would all have the same expiration date. So, you would have to go through multiple evolutions before you would have that graduated expiration time.

Mr. MEIJER. Thank you, Doctor. I guess, quickly for Ms. Clowers. I know, and again, I just wanted to—Representative Slotkin's desire to have to really hit home on this issue of making sure that either onshoring or, frankly, an issue that I want to kind-of get your thoughts on, the issue around some of the domestic manufacturers who have spun-up their production capability since the start

of the pandemic. You know, some existing manufacturers like 3M but others and Prestige Ameritech, but other kind-of smaller entities have also spun-up to meet that, but are having issues accessing, frankly, markets for their products even while we do have PPE shortages because of legacy supply chain dynamics of either large hospital systems or State-based purchasing efforts. Can you share a little bit more on how we can, frankly, keep some of those domestic manufacturers that have risen to the challenge to meet this need in the pandemic, how we can make sure that we not only are finding markets for them today, but also retaining that domestic capability around PPE manufacturing so we are not experiencing the supply chain risks and the shortages that we saw at the beginning of the pandemic.

Ms. CLOWERS. Absolutely. This is an area that we have on-going work looking at the medical supply chain. I would be happy to as we get further along in the work, to brief you in terms of what we are finding. But you are hitting on the key issues. It is both incentivizing the companies to do the necessary research and development for the medical countermeasures, for example. But then also, helping them find those markets. I think there are lessons that we can learn from existing programs. BARDA within HHS has a program that is designed to do this. It has not been utilized as much as it maybe will be going in the future, given the current pandemic. But there are other financial incentives the Government could bring to bear. Again, we are looking at all those issues and we will be happy to brief you when we have that work ready.

Mr. MEIJER. Thank you, Ms. Clowers. Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The Chair recognizes the gentlelady from Florida, Ms. Demings, for 5 minutes.

Ms. DEMINGS. Thank you so much, Mr. Chairman. Thank you so much for your leadership on this very important topic and important committee. You know, my friend and colleague from South Carolina said earlier that I am one that follows the data. That is a good thing. What we do know on this committee, every Member, is that Black and Brown communities have been hardest hit by contracting the virus, by hospitalizations, and by deaths. Black and Brown communities have been left behind in testing and now in vaccine distributions. The statistics that we have quoted several times earlier today that life expectancy has changed by 1 year, but for African American communities, it is by 3 years. That is the data.

To identify and address equity gaps in vaccine distribution, the CDC requires all States to submit demographic data on those who receive vaccines. I am troubled though that today, only 34 States are doing it. Only 34 States think the data is important. This is why I have joined the Chairman in writing to FEMA to urge FEMA to double-down, redouble its efforts to secure such data from the States. Facts in Florida are also troubling, my home State, where 10 percent of White Floridians have been vaccinated, while 4 percent of African Americans and 4 percent of Hispanics have been vaccinated. I ask unanimous consent to submit that letter, Mr. Chairman, dated February 23 into the record.

Chairman THOMPSON. Without objection, so ordered.

[The information follows:]

Submitted for the Record by Mrs. Demings

BENNIE G. THOMPSON, MISSISSIPPI
CHAIRMAN

JOHN KATKO, NEW YORK
RANKING MEMBER

One Hundred Seventeenth Congress
Committee on Homeland Security
U.S. House of Representatives
Washington, DC 20515

February 23, 2020

Robert J. Fenton, Jr.
Acting Administrator
Federal Emergency Management Agency
500 C Street, SW
Washington, DC 20472

Dear Acting Administrator Fenton:

We share President Biden's view that that the Federal government and its State, Local, Tribal, and Territorial (SLTT) partners have a duty to ensure equitable access to COVID-19 vaccines. As such, we strongly support Federal efforts to encourage the collection and maintenance of reliable demographic data regarding COVID-19 vaccine and urge the Federal Emergency Management Agency (FEMA) to work with States to report such data.

Specifically, we support the Centers for Disease Control and Prevention's (CDC) requirement that SLTT partners maintain a process for COVID-19 vaccine recipients to voluntarily provide their demographic data, including race and ethnicity.[1] Unfortunately, only 34 states currently report COVID-19 vaccination data by race and ethnicity.[2] Robust data maintenance, as directed by the CDC, will not only inform efforts to provide greater equity in vaccine distribution and administration planning, but will also help SLTTs fulfill Federal cost share reimbursement requirements.[3]

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[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, COVID-19 Vaccine Administration and Reporting Requirements (01/07.2021).
[2] Nambi Ndugga, Olivia Pham, Latoya Hill, and Samantha Artiga, Coronavirus (COVID-19), *Latest Data on COVID-19 Vaccinations Race/Ethnicity*, Kaiser Family Foundation, (Feb. 18, 2021); and *see* Marty Johnson, *Vaccine inequity prompts calls for federal response*, The Hill, (Feb. 07, 2021).
[3] U.S. Department of Homeland Security, Federal Emergency Management Agency, *COVID-19 Pandemic: Vaccination Planning FAQ* (Nov. 19, 2020).

Pursuant to section 308 of the Stafford Act, accompanying regulations, and U.S. Department of Homeland Security guidance, FEMA has a responsibility to ensure nondiscrimination in the provision of disaster assistance.[4,5] We are pleased that FEMA recently published an advisory entitled, "Civil Rights Data Collection" reminding States of their responsibilities and that more focused assistance may be needed to assist some States that are struggling to comply with the CDC data requirement.[6] We are also pleased that FEMA has told States they must operate in a manner that is "consistent with CDC guidance and PA [Public Assistance] program requirements" to receive reimbursement for costs incurred for vaccine distribution and administration activities.[7] However, at this time, we urge FEMA to intensify its engagement with non-compliant States, work to overcome non-compliance, and reinforce to States that seek reimbursement that they are obligated to collect such data.

Although many States are not reporting vaccine data by race and ethnicity, the data that is available suggests inequities are alarmingly high. According to the Kaiser Family Foundation, "…Black and Hispanic people continue to receive smaller shares of vaccinations compared to their shares of cases and deaths and compared to their proportions of the total population."[8] FEMA must work to ensure the communities disproportionately affected by COVID-19 are able to access vaccine. To that end, we were pleased to learn of the establishment of the Civil Rights Advisory Group within FEMA to help SLTT partners identify and address vaccine access barriers in underserved populations. It is an encouraging step; however, these efforts must be informed by data.

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[4] Pub. L. No. 93-288, as Amended, 42 U.S.C. 5121 et seq., Related Authorities, *FEMA P-592* (May 2019).

[5] *See* 44 CFR §206.11 Nondiscrimination in disaster assistance; 44 CFR Part 7 Nondiscrimination in Federally-Assisted Programs; and U.S. Department of Justice, Homeland Security, Housing and Urban Development, Health and Human Services, and Transportation, *Guidance to State and Local Governments and Other Federally Assisted Recipients Engaged in Emergency Preparedness, Response, Mitigation, and Recovery Activities on Compliance with Title VI of the Civil Rights Act of 1964* (2016).

[6] U.S. Department of Homeland Security, Federal Emergency Management Agency, *FEMA Advisory: Civil Rights Data Collection* (Feb. 2021).

[7] U.S. Department of Homeland Security, Federal Emergency Management Agency, *COVID-19 Pandemic: Vaccination Planning FAQ* (Nov. 19, 2020).

[8] Nambi Ndugga, Olivia Pham, Latoya Hill, and Samantha Artiga, Coronavirus (COVID-19), *Latest Data on COVID-19 Vaccinations: Race/Ethnicity*, Kaiser Family Foundation, (Feb. 18, 2021); and *see* Marty Johnson, *Vaccine inequity prompts calls for federal response*, The Hill, (Feb. 07, 2021).

We strongly believe that FEMA has an important role to play to aid States' efforts to set up systems to collect and report COVID-19 vaccine demographic data to not only help ensure PA eligibility for reimbursements for costs associated with vaccine distribution and administration, but also ensure our country's response to the pandemic is more equitable.

Thank you for your attention to these matters.

Sincerely,

Bennie G. Thompson
Chairman

Val Demings
Chairwoman
Subcommittee on Emergency,
Preparedness, Response, and Recovery

Ms. DEMINGS. You know, we are a Nation where we always go where the need is greatest. So, I have to ask the question, what is going on now? For a Nation who always goes where the need is greatest, but we see the data. So, Dr. Watson, I would like to start off with you because we are not doing well going into the areas where the need is greatest. Could you just talk a little bit about President Biden's Health Equity Task Force and how it can help us at this particular area?

Ms. WATSON. This is an excellent point. I think, unfortunately, going where the need is greatest sometimes is also the hardest thing to do, because we don't have established connections. We haven't prioritized reaching the most vulnerable populations in the

past. So, what we need now is to make that a top priority to provide States with the resources to do that. To connect with community organizations in populations that we want to reach and to ensure that we are getting vaccination, we are getting testing, and we are getting access to health care in all these vulnerable populations.

Ms. DEMINGS. So, Dr. Watson, those are some of the lessons learned, as we come out of this public health pandemic and prepare, unfortunately, for the next one, those are some of the vulnerabilities that we as a response—the Nation that responds, suffers from. Is that what you are basically saying?

Ms. WATSON. Certainly. There are underlying factors that have been present long before COVID–19 that we need to address more systemically. But in this response, specifically, it will also take concerted effort to reach the people who we want to be vaccinated and protect.

Ms. DEMINGS. So, and we know better because we like to say this that we are supposed to do better. That is what we say. Ms. Clowers, in cases where States have not adequately made vaccinations available in Black and Brown communities, what are FEMA's thoughts in making trusted venues like churches, community centers, and senior centers designated sites?

Ms. CLOWERS. That is exactly what the different agencies are working on right now, Representative. CDC, FEMA, and others looking at putting sites in places where people have better access to that are more familiar, but also places of trust as you mentioned. It is not only the location of those facilities, but it is also the messengers. Enlisting the community leaders that people trust and having them help educate everyone about the importance of the vaccine, for example.

Ms. DEMINGS. OK, thank you so very much. You say that is what they are currently working on. How would you assess those efforts because people are dying as we well know, everyday?

Ms. CLOWERS. I would say it is very early. Unfortunately, it goes back to what Dr. Watson was saying. You know, we are building off historic health disparities in this country. Disparities and systematic biases that have been built into the system over years, and what the pandemic is revealing those to us. So, we need to undo those as we go forward. Hopefully not only with this pandemic, but in the future moving beyond.

Ms. DEMINGS. Part of our job as elected officials is to address those systematic biases. Thank you very much. Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. The gentlelady yields back. The Chair recognizes the other gentlelady from Florida, Ms. Cammack, for 5 minutes.

Ms. CAMMACK. Well, thank you, Mr. Chairman. Thank you too Ranking Member Katko. Also, thank you to our witnesses for appearing before the committee today. There is absolutely no question that COVID highlighted the vulnerabilities in the U.S. domestic supply chain that had plagued us for decades from PPE to our domestic food supply. The United States relies heavily on China as a large source of components that are critical to our Nation's supply chain that are vital to U.S. operations and National security.

I know that many of my colleagues share the same concerns on both sides of the aisle. It is crucial that we prioritize domestic production of these supplies that are critical to the National security, where possible. We need to diversify our sourcing elsewhere.

Now, this question is specifically for Ms. Clowers. We have heard a lot today about supply chain concerns, but I want to dig in a little bit more on the sourcing of raw materials, for example. We saw major supply shortages that proved incredibly challenging in the beginning stages of the pandemic and highlighted our overdependence. But much of the materials required to manufacture critical PPE are produced overseas in loosely or non-regulated environments like China. Materials like polypropylene, which are melted down and sprayed to make the nonwoven medical masks, for example. My question to you is given the regulatory environment that we are facing in this new administration, how would you recommend bringing these critical base materials and raw materials back to the United States, given that this administration has stated that they are going to increase the red tape in regulatory environment?

Ms. CLOWERS. Regarding the domestic supply chain as well as looking at how that fits into the global supply chain, you highlighted examples of the raw materials for devices of PPE. I would add that also affects drugs as well, as much of the active pharmaceutical ingredients that are used for drug manufacturing are overseas. As I mentioned earlier, a lot of that production occurs in countries like China and India. So, when there is a pandemic or other type of incident that affects the supply chain, it could have an immediate negative effect on the health care system as we saw now.

I know that the current administration has announced plans to assess the supply chain and identify gaps and what measures are needed to be taken. That is something we will be monitoring and we will report on that progress and any challenges that we see in future reporting.

Ms. CAMMACK. As a follow-up to that, what is the time line on that?

Ms. CLOWERS. We have on-going reporting. We will be issuing our next report in March. Then we have specific looks looking at the supply chain and as it relates to specifically API that will be coming out later this year. I could get you those exact time frames. We are happy to, as that report is coming out, brief you and your staff on it.

Ms. CAMMACK. I appreciate that. Thank you. My next question is addressing one of my top issues that I have here in Congress, which is access to broadband. One of my major priorities is increasing access and affordability to broadband, specifically, in rural and underserved communities. In a pandemic like we have been facing, access to real-time reliable information is especially important. So, with so many people lacking reliable internet access, especially in these rural and urban communities that are underserved, how can the Federal and State government ensure that everyone has knowledge of and access to COVID information and vaccine availability? I am opening this up to anyone on the panel who would like to answer this.

Dr. EZIKE. Thank you for this important issue. So, we have seen that that digital divide affects individuals in educational settings. It affects adults who may be trying to get information about COVID. So, we have expanded call centers, increased the number of operators so that people have the option to just call if, you know, searching through internet is not an option. That people can talk to a live person who can assist with getting vaccination, especially are trying to focus on our over-65 population. In Illinois, which is consistent with what is happening across the country, 85 percent of the deaths for COVID have occurred in individuals over 65. So, it is really a priority to make sure that those individuals have access to the vaccine, whether they have access to the internet or not.

Mr. MCMAHON. I would add, as well, that the digital divide has been real throughout the pandemic. Broadband is something as a country we have to address immediately. But specifically, to vaccine rollout, our seniors are confused by the multiple distribution points. So, to date, what we have done locally as well, is we have created call centers. We have created waiting lists where seniors can call the call center and then we are logging in their waiting lists so that they—and then we are calling the seniors, not just emailing the seniors when they have appointment times. So, you really have to adapt and meet the need all hands on deck with this divide that we have right now.

Ms. CAMMACK. OK, thank you so much. With that I yield back.

Chairman THOMPSON. Thank you very much. The Chair recognizes the gentlelady from California, Ms. Barragán, for 5 minutes.

Ms. BARRAGÁN. Thank you, Mr. Chairman, for holding this very important hearing. I have heard a lot of discussion about the Biden administration's effort to restore asylum processing at the Southwest Border. Let me be clear. No one in the MPP program tested positive, and testing is happening aggressively. I was just there. So, so disturbed to hear some of the commentary and make we get accurate information.

Now, FEMA recently opened 2 managed vaccination sites in my home State of California, each with the capacity to vaccinate 6,000 people a day. This is an amazingly great development. But more FEMA sites need to be added, especially in districts like mine where I have a district that is almost 90 percent Latino, African American, the fourth-poorest in California, and has been hit especially hard during this pandemic. Dr. Ezike, what are the benefits of having the Federal Government run vaccine centers to augment State capabilities?

Dr. EZIKE. Thank you for that question. So, of course, this pandemic has stretched every public health department well beyond their natural abilities. So, in addition to vaccination, of course, there is testing. There is contact tracing. There is genomic sequencing. Of course, on top of the normal work of public health, looking out for lead, STIs, tuberculosis. So, being able to have that Federal support in terms of FEMA with these very productive high-throughput sites, that allows us to shift energy on harder-to-reach populations that may not be able to get to the vaccination sites sponsored by FEMA, but need mobile teams that the health department can focus on getting those very hard-to-reach communities as

well. So, we just need that coordinated large-scale effort to make sure that all of this important work gets done.

Ms. BARRAGÁN. Great, thank you. Ms. Clowers and Dr. Watson, as I said earlier, I support FEMA aggressively making vaccination efforts. It is important that the location selection prioritize availability to those at greatest risk. This includes underserved communities and communities of color, like in communities—communities very much like my very district that have been hit very hard. Due to the——

Chairman THOMPSON. I think we lost your connection, Congresswoman. Can you hear me?

Ms. BARRAGÁN [continuing]. As FEMA considers supporting sites.

Ms. CLOWERS. I'm sorry, Representative, I missed the question.

Ms. BARRAGÁN. Sure.

Chairman THOMPSON. We had some technical difficulties. I will yield back to the lady an additional minute to get her questions through.

Ms. BARRAGÁN. Great. Dr. Watson, back to FEMA aggressive—I support FEMA aggressively helping vaccination efforts including serving underserved communities. What are your thoughts on how vaccine equity can be addressed as FEMA considers supporting sites?

Ms. WATSON. So, I think that is a very good question. Obviously, making these vaccination sites accessible by communities of color, in particular, but also other underserved communities. Then also working directly with health departments who know their communities very well to understand how to do some more microtargeting of communities to help them understand about vaccination. To get them appointments for a vaccination and get them access. So, it is a combination of these large sites, which FEMA is well-placed to help with. But then also working with established networks through public health and other parts of your State to really understand how to target vaccination more specifically.

Ms. BARRAGÁN. Thank you. Ms. Clowers, is there anything you would like to add?

Ms. CLOWERS. In addition to what my panel member mentioned, I do know that FEMA is also conducting a pilot program with vaccination sites including in California. Where they are going to be using CDC data on using the vulnerability index, as well as other census data to help locate where those sites should be. I think that is a positive development. We will monitor closely how that pilot runs.

Ms. BARRAGÁN. Great, thank you. One of the outbreaks in my district and we have seen is the complex ports. It is the ports of Los Angeles and Long Beach. There have been serious COVID–19 outbreaks. My concern is of a possible shutdown and what the implications can be to National security if something were to happen to the ports and, you know, the serious outbreak. But, Dr. Watson, given how vital ports are to this country especially the largest by container volume in my very district, are to the economy, should COVID–19 outbreaks at these facilities be treated as a serious threat to National security?

Ms. WATSON. I think it is really important to maintain our infrastructure and as you said, ports are very important to our National

security. So, fortunately, there are public health mitigation measures including frequent testing and contact tracing and supporting people to stay home when they are sick, and if they have to quarantine because of a significant exposure. So, all of these measures are things we can do for the broader population. But if they are a little bit more targeted, then we can help prevent these big outbreaks at ports.

Ms. BARRAGÁN. Great, thank you. I just want to thank you again, Mr. Chairman, for having this hearing. We know that we have a new administration who has come in and is taking this seriously. Who has put forward the American Rescue Plan and has involved the Federal Government in being a partner and now getting these FEMA sites up, which are great, and getting mobile units out. With that, Mr. Chairman, I yield back.

Chairman THOMPSON. The gentlelady yields back. The Chair recognizes the gentleman from Texas for 5 minutes, Mr. Pfluger.

Mr. PFLUGER. Mr. Chair, thank you. Panelists, thank you very much. I appreciate the discussion. Ms. Watson—Dr. Watson—my apologies—the strategy that the President has outlined, are you in agreement with that as being a strategy that can work for our country to halt this pandemic and fight back against it?

Ms. WATSON. I think in broad strokes, yes, I am in agreement with the current trajectory, yes.

Mr. PFLUGER. OK. What areas do you disagree with?

Ms. WATSON. I don't have any specific disagreements off the top of my head. But broadly, I am in agreement.

Mr. PFLUGER. OK. One question I want to ask you. When it comes to, you know, there was a couple of Executive Orders that were issued promoting COVID–19 safety in domestic and international travel, and also in the equitable response and recovery. How do we make those decisions? A lot of my colleagues have previously stated today that their districts are being hit particularly hard in underserved districts and in populations who may not have that access. How do we pick and choose who is going to get the vaccines? As I understand it 60 million have been distributed so far.

Ms. WATSON. So, not being in Government and part of those conversations, it is hard for me to comment specifically. But I know there are, I think, it is population-based allocation primarily. But then also risk-based decision making also occurs.

Mr. PFLUGER. So, as I understand it and from your perspective, would you say that we have limited resources at this point in time to cover our whole population in a timely manner at this second?

Ms. WATSON. Yes, I don't think the supply that we have right at this moment meets the demand for vaccine.

Mr. PFLUGER. So, diverting supply away from the areas that need it the most would not be a good plan for us?

Ms. WATSON. I think we need to assess where we need vaccination the most, but we need broad coverage across the country. There has been considered planning in terms of who should be vaccinated and in what order. So, we need to continually reassess that to ensure that it is going in the way that we want it to.

Mr. PFLUGER. Do you believe it is going in the way you said in broad strokes you agree with the plan?

Ms. WATSON. Yes, I think the sequenced rollout of vaccine is reasonable. Obviously, I think we have some underserved populations that are not being reached at this moment. So, we need to reassess how we can get vaccine to be more equitably distributed. But I think the general plan is reasonable for the country.

Mr. PFLUGER. Thank you very much. Dr. Ezike, do you also believe that, you know, the limited resources that we have in this country should be applied, you know, I think it is, you know, broad strokes, you know, throughout the country, but also to places that need it the most?

Dr. EZIKE. Yes, sir. I believe that we have to get as much vaccine out as quickly as possible, but it needs to—that plan has to be infused with equity to prevent additional disparity.

Mr. PFLUGER. What would you say about the rural areas, underserved rural areas?

Dr. EZIKE. I think that is an area that needs particular attention. That there is geographic equity that needs to be considered as well. We also know that, at least in the State of Illinois, we have rural areas, southern regions of the State, that have some of the worst health outcomes. So, those are high-risk settings that have higher risks that actually need concerted attention and efforts.

Mr. PFLUGER. So glad to hear you say that. Ms. Clowers, do you also agree that those rural areas need help as do urban areas, underserved areas?

Ms. CLOWERS. Yes. We documented that in our work as well in terms of rural access and how access to health care facilities and treatment can affect those populations.

Mr. PFLUGER. Very good. I appreciate you-all's discussion on that. My main concern right now, Mr. Chairman, is the fact that any diversion of any of our resources away from those in this country who need it the most, is a tragedy. Whether it is rural, or urban, or underserved, or any population in the country that needs to get access to vaccines. My district is incredibly rural and we have a very difficult time with the access to that. So, when it comes to folks that need it the most, we need to make sure that they are getting that. Specifically, in my case, a rural district. So, I have a very hard time understanding how the President's plan does not take into account a strategy when it comes to international travel, especially overturning immigration policy that would put us further at risk and not get those resources and vaccines to those who actually need it the most, as all of our witnesses have just agreed to. With that, Mr. Chairman, I yield back. Thank you very much.

Chairman THOMPSON. Thank you very much. The gentleman yields back. The Chair recognizes the gentleman from New Jersey, Mr. Gottheimer, for 5 minutes.

Mr. GOTTHEIMER. Thank you, Mr. Chairman. COVID–19 has taken an immense toll on communities I represent in northern New Jersey, where we were hit early, unfortunately, and found ourselves in the eye of the COVID–19 storm. Almost a year later, we are still working hard to get through the pandemic. I recently visited vaccine sites across northern New Jersey, including in Teaneck at Barada Community Center run by Holy Name Medical Center, at Bergen's New Bridge Medical Center, at the Sussex County Fairgrounds, and the Meadowlands. Thanks to our front-line per-

sonnel who have done such a great job of setting those up and running them. As you know, many of the vaccine distribution systems are still being set up and we are working hard to expand vaccine availability. I was very encouraged by the President when he recently announced that there will be an increased flow of vaccine doses headed to the States——

Chairman THOMPSON. I think the gentleman from New Jersey is having some challenges. We will work through those challenges. Mr. Torres, if you are ready. We will yield to you at this time. Mr. Torres, if you can get on, we will go to you while we work out the challenges with Mr. Gottheimer. Well, it must be a New York, New Jersey thing. We will go to the other gentleman from New Jersey.

Mr. TORRES. Mr. Chair, I'm sorry. Did you call? Mr. Chair, I'm sorry. I see Josh is back.

Mr. GOTTHEIMER. I'm sorry, Mr. Chairman. It appears I had internet problems.

Chairman THOMPSON. Well, it looks like everybody's having problems. Mr. Garbarino, are you available to talk? We are still not able to hear any of our last 3 members. Must be a system adjustment. Well, we are not really sure what it is. Mr. Torres, can you hear me?

Mr. TORRES. I can hear you, Mr. Chair.

Chairman THOMPSON. Well, if you could hear me, please go ahead with your 5 minutes.

Mr. TORRES. OK. Thank you, Mr. Chair. It is refreshing to have a new President who is committed to crushing the virus rather than crushing our democracy. When it comes to pandemic response, timing is a matter of life and death. Delay is deadly. The longer the delay, the higher the death toll. If the Trump administration had put in place social distancing restrictions at the beginning of March, it would have cut the death rate by as much as 90 percent. We as a Nation have paid a heavy price and the lives of a half a million Americans for the lethal incompetence of the Trump administration.

My first question is about the way forward. There is no return to normality without population immunity. What is the time line for achieving a population immunity? Are we confident that population immunity can be achieved given the systematic failure to sufficiently vaccinate communities of color? Communities of color like mine are often the first to be hit the hardest and the last to be vaccinated. This question is for the Government Accountability Office.

Ms. CLOWERS. In terms of when we will reach societal immunity, I think it is a question to be determined. I have seen some suggest it could be earlier this spring. To some, that it will be much later into the year. Certainly, a number of factors would drive that. One is the how well we do with the vaccinations over the next several months. Are we able to get the supplies that we need in terms of doses and get them out and into the arms of Americans? That is really going to drive in terms of how quickly maybe we can get back to somewhat normal life.

But in terms of—we have also heard the experts talk about that we will be continuing to need to utilize public health measures such as social distancing and masking for the foreseeable future be-

cause of hard-to-reach communities and making sure that everyone in the United States is vaccinated to the extent that they can be. But also, we live in a global society and until we are—see the containment of the virus across the world, all of us are at risk. So, it will be many months, but it is something that we will be watching very closely.

Mr. TORRES. Is there a concern that we might fail to achieve population immunity before the emergence of new strains that render the vaccines ineffective? Is that a concern?

Ms. CLOWERS. Well, that is certainly—it is certainly a concern among the public health community and my colleagues might want to address that. But it is a race with the vaccination against new variants. Viruses are constantly mutating. A lot of those mutations don't prove effective for them, so, they die out. But certainly, as long as there is host in order for them to continue to mutate, that is a problem. That is why we want to get as many people vaccinated as quickly as we can.

Mr. TORRES. I do have a question for Dr. Watson about the future of SARS–CoV–2. You know, some viruses like SARS–CoV–1 and MERS get eradicated. Some viruses like influenza remain endemic. Is COVID likely to remain with us in a post-COVID world? Knowing influenza kills tens of thousands of people every year, is COVID going to kill tens of thousands of Americans in a post-COVID world?

Ms. WATSON. I am not a virologist and so, and I don't even think my colleagues who are virologists know the answer to this yet. But I do think we are seeing increasing information that makes it more likely that COVID, SARS–CoV–2 will remain with us not just in this pandemic, but beyond. It maybe something that we face on an annual basis. So, we need to gather more data and try to understand what that looks like. But then also pay close attention to our vaccination efforts and determine whether we need to update vaccinations over time and people need to be revaccinated. But there are so many unknowns with this right now.

Mr. TORRES. My final question is what can be done to bolster the rates of vaccination within communities of color? I just find the rates to be alarmingly low. It is going to undermine our ability to achieve some semblance of normalcy. So, any thoughts of what can be done to bolster vaccination within communities of color?

Dr. EZIKE. I can take that. I think there is hope. You are correct that our communities of color have lower acceptance rates of the vaccine. But all of the individuals that have said no—many people who have been offered the vaccine and said no, they do fall into different buckets. There are individuals that are simply not first. They weren't ready to get it when it was first offered. They didn't want to be amongst the first individuals to get it. As other people have gotten it, as the tincture of time has passed, they have come around and have come maybe on a second and third visit, third offering, have not taken it.

We have some people that were just not sure and so, they still needed to gather more information. They needed to seek reassurance from trusted messengers whether it is in the faith community or medical providers that are trusted. Then there are some that

are, you know, not ever. So, you know, I think the not ever are a smaller group.

So, there is still lots of work to be done in terms of community engagement and working with trusted messengers. Giving out culturally appropriate messages, virtual town halls. Using venues and people that can be trusted to share the message. We have had lots of physicians and medical individuals of color who have been documenting their COVID vaccine journey, and I think that has helped. We have lots of, you know, personalities that have come out to share their COVID journey. I think with time as people see the safety and the efficacy of this vaccine, you will have more of those individuals come. So, but we have to continue the engagement.

Mr. TORRES. Thank you.

Mr. MCMAHON. Congressman, if could add on that, I think method of distribution matters. With our success, we have had within our minority populations, we have worked with credible messengers. We have worked with churches. We have had pop-up clinics at housing authorities. We have worked into our—looking at library systems in the neighborhoods with pop-up clinic models. We have not had as much participation with new American communities in the traditional mass vaccination sites. Even though one of our mass vaccination sites is in the heart of a neighborhood in our downtown right next to one of our poorest neighborhoods. So, I think method of distribution really matters as well with credible messengers.

Chairman THOMPSON. Absolutely. The Chair recognizes the gentleman from New York, Mr. Garbarino, for 5 minutes.

Mr. GARBARINO. Thank you, Mr. Chair. Is it working?

Chairman THOMPSON. Yes, you're working.

Mr. GARBARINO. Wonderful, all right. Thank you very much. I just have a quick I think follow-up, a few questions. Dr. Ezike, you spoke about getting the vaccine out there as much as possible to all different sorts of groups. The Biden administration launched the first phase of the Federal Retail Pharmacy Program allowing pharmacies to distribute vaccine doses. Has this initiative been successful so far in Illinois?

Dr. EZIKE. Well, I think as with the entire vaccine rollout, with these very complicated vaccines, there are been a steady increase. Steady increase in the throughput, steady increase in the comfort of getting it done. So, I think we have—we are very excited that all of our long-term care facilities that were enrolled in the program, and we had many. We had over 1,400 facilities that were enrolled. But I think we have had all of our skilled nursing facilities have at least one visit. We expect all of them to be done in the coming weeks. We have already moved on to our long-term care facilities and other congregate care settings. So, you know, everything has been a learning curve, but we have been—we have had great partnership with our CVS and Walgreens partners. We have been working on the phone every week, multiple times a week to make sure that we iron out kinks. When we hear about long-term care facilities that have a complaint or an issue, we have been able to take that back to make sure that we keep correcting and improving the process as we go along.

Mr. GARBARINO. But so, the pharmacy—so far what you have seen with the pharmacy program with this like you said CVS and the Walgreens, it has been a positive? It is increasing, or is it—it is increasing the doses that are being administered? Would you say that?

Dr. EZIKE. Yes, it is helping us get more vaccinations in arms. So, we are grateful for the partnership. We need many different partners for this effort.

Mr. GARBARINO. Great. I appreciate that. Thank you. I just want to move on, Ms. Clowers. Hopefully, I got that right. There are 2 questions I had. No. 1, you talked about in your testimony you mentioned that HHS data on COVID–19 in nursing homes is incomplete because they didn't require the first—in the first 4 months of the pandemic to report data. Has there been any—and I apologize if this has been asked. But has HHS done anything to go back and get that data or anything to try to recap that data so we have a full picture?

Ms. CLOWERS. They have not. We continue to believe that is a really important step for them to take. As you may know, that until May of last year, nursing homes did not have to report cases and deaths to CMS. In May, CMS put out information to them and said you are going to start at this point reporting that information to us going forward. But they didn't have the nursing homes go back to the beginning of the pandemic and report that information.

We think it is really important that that information is captured because that is information that could help us better understand the spread. Especially during that period through that vulnerable population. I can give you a quick example of how this data affects and the types of data that we are missing.

As you might remember, it was about this time last year one of the first sites of spread was in the Kirkland Nursing Home in Washington. If you look at the HHS data, it will show during that there were zero cases and zero deaths in the beginning months of the pandemic for that site. Well, of course, we know there was over 100 cases and unfortunately about 23 deaths in that nursing home. So, that is just one example of a piece of data that is missing. We think all that data needs to be collected. We think it can be done in a fairly non-burdensome way for nursing homes to report that information so we have better insight in terms of what was going on during that time period.

Mr. GARBARINO. That is great. That was my next question, whether or not we could get enough good data that it would actually make it because that is great. I agree with you, I think we should get that. As you know, my State of New York we have had quite a—this has been in the news quite a bunch lately. It is something I dealt with when I was in the assembly last year on the health committee. So, I think it is very important we get that information.

Just another question, you know, a lot of documents have been, strategy documents have been issued in the last several years that may encompass a portion of the COVID response. You know, in 2005, HHS developed a pandemic influenza plan. The Biden administration just recently released the National Strategy for COVID–19 Response Epidemic Preparedness. Are there anything

in these plans that—these strategic plans are missing? Is there something that are in these plans in your opinion that—or that are not in these plans, but should be?

Ms. CLOWERS. In terms of the past plans that we have reviewed, we did find elements were missing. Everything from very clearly stating what the risks are, what our goals were. What would be benchmarks for success, consistent definitions, as well as the resources that are needed. The new administration has put out the response plan. We are currently evaluating that. We are also waiting for additional plans that are to be forthcoming that were required by Congress, the additional testing strategy that should be coming out at the end of March, and we will review that to see to make sure that it contains all the information that is necessary for an effective strategy. I will note, then it is really important that these strategies are publicly available so that everyone understands those roles and responsibilities.

Mr. GARBARINO. OK. I appreciate that and look forward to hearing more about it. Thank you. Last, Mr. McMahon, I just wanted to say my friend, Bill Barkley, says hello.

Chairman THOMPSON. The gentleman's time has expired. The gentleman's time has expired. The Chair is going to recognize, again, the gentleman from New Jersey, Mr. Gottheimer.

Mr. GOTTHEIMER. Thank you, Mr. Chairman. Is this better?

Chairman THOMPSON. Much better.

Mr. GOTTHEIMER. Sorry, about that. As I was saying last time, COVID–19 has taken an immense toll on northern New Jersey where I represent. We got hit early and very hard and found ourselves in the eye of the COVID–19 storm. Almost a year later, we are still working hard to get through the pandemic. I have recently visited vaccine sites across my district in northern New Jersey and Teaneck at a center run by Holy Name Medical Center, at Bergen New Bridge Medical Center, at the Sussex County Fairgrounds, and at the Meadowlands to thank our front-line personnel for helping distribute the vaccines.

As you know, many of the vaccine distribution systems are still being set up and we are working hard to expand availability. I was deeply encouraged when the President recently announced that there will be an increased flow of vaccine doses headed to States and communities like ours. The administration also announced plans to buy 100 million additional doses of the Moderna and Pfizer vaccines and the Food and Drug Administration today endorsed the emergency authorization request from J&J, a great New Jersey company, for their new COVID vaccine. With the final authorization hopefully coming later this week. We need to keep up the pressure until we can fully deploy vaccines across the country to help us safely reopen. Dr. Watson, how can we help accelerate the production and deployment of vaccines? What sort of role can FEMA play in that effort?

Ms. WATSON. I think the Government is working really hard to accelerate the production. I don't have any specific comments on that although I think there are lessons that we can learn for the next pandemic there in improving production capacity in the United States. But in terms of roll-out, I think FEMA is an excellent partner as was discussed briefly earlier in setting up vaccina-

tion sites and helping States coordinate vaccination efforts. As long as it is being coordinated with the health department, I think that can be a great asset. So, it is one thing I think we need to look back at our previous plans and maybe reassess in the future what is FEMA's role in these types of public health emergencies because I think they haven't formally been engaged in our plans to the extent that we realized they have been needed in this response. So, I think that is a good thing for our after-action reviews.

Mr. GOTTHEIMER. Thanks, Doctor. Do you agree we should deploy these pop-up vaccine sites in every Congressional district including in rural areas to make sure we reach those underserved populations?

Ms. WATSON. Yes, I think as my colleague, said, every connection, every partner in this effort for vaccination is probably appreciated.

Mr. GOTTHEIMER. Thank you so much. I appreciate that. Mr. McMahon, as a county executive, you have experienced first-hand the immense challenges faced by our local counties, towns, and municipalities during the COVID–19 pandemic. Across Jersey, our communities have been hit hard. Some of them facing unfortunate tasks of having to lay off essential and front-line workers or making painful budget cuts to essential programs and services. Can you discuss how this is a bipartisan issue for States like New York and New Jersey and what the grim outlook is for our communities if we in Congress fail to provide robust aid to our State and local governments as part of our next relief package?

Mr. MCMAHON. Yes, I really do see this as a bipartisan issue. Essentially, in New York what was unique with our situation is we didn't receive direct aid in the CARES Act, like many communities under half a million in their population. Because of that we had to make mid-year budget cuts in 2020. We had to incorporate those cuts into 2021 for my community. We are a $1.3 billion budget. In 2021, we made $84 million worth of cuts. We had retirement incentives. We had furloughs. We had layoffs. We want to bring back some of these people. I have people in my adult and long-term care department doing contact tracing. My social services doing contact tracing.

There are other elements in the pandemic. I referenced earlier that the human services side of this pandemic is going to be glaring next year and later in 2021, when we are done vaccinating. So, the aid is important if we want to shore up our efforts. When you look at recovery efforts, we are large employers. We are large spenders. We buy capital. We pave roads. All these budgets got cut drastically in 2020 and '21.

Mr. GOTTHEIMER. Thank you so much. I yield back, Mr. Chairman. Thanks again for coming back to me despite the technological issues here.

Chairman THOMPSON. Thank you very much. Well, given the level of Member participation in this hearing, obviously there has been great interest and impact more importantly in their respective areas. Let me thank the witnesses for their testimony and the Members for their questions. The Members on the committee may have additional questions for the witnesses. We ask that you respond expeditiously in writing to those questions.

I don't want to underemphasize rural underserved communities. I have 26 counties in my district. Thirteen of those counties we don't have a Walmart. We don't have a Walgreens and we don't have a CVS. But we have churches. We have schools that have buildings and other things. So, I am working trying to get people to go beyond just what the printed paper requires in order to get people vaccinated. So, I really thank our witnesses for helping the committee. You have gotten us to a good point where we can work with this administration on overcoming this pandemic. Collectively we can do this. Your testimony adds immensely to getting us there.

Without objection, the committee record shall be kept open for 10 days. Hearing no further business, the committee stands adjourned.

[Whereupon, at 12:59 p.m., the committee was adjourned.]

APPENDIX I

Submitted for the Record by Mrs. Harshbarger (2/26, via email)

Statement for the Record

Matthew J. Rowan

President and CEO

Health Industry Distributors Association

On

"Confronting the Coronavirus: Perspectives on the COVID-19 Pandemic One Year Later"

Before

House Homeland Security Committee

February 24, 2021

Thank you for convening the House Homeland Security Committee hearing, "Confronting the Coronavirus: Perspectives on the COVID-19 Pandemic One Year Later." This hearing can play an important role in identifying lessons learned from this pandemic, and how they can be applied to future public health crises.

To assist in these efforts, the Health Industry Distributors Association (HIDA) is attaching an infographic and our white paper, "Building A More Robust Supply Chain: A Public-Private Framework to Create A Pandemic Response Infrastructure," that outlines steps to strengthen our medical products supply chain. We believe the public and private sectors must work together to:

1. Make the supply chain more robust, utilizing the nation's 500 commercial distribution centers to forward deploy critical products
2. Diversify sourcing
3. Expand and support surge manufacturing capacity and
4. Prevent development of a fraudulent opportunistic marketplace.

The framework of this strategy was the basis for bipartisan legislation (H.R. 6531 and H.R. 7574) which was passed by the Energy and Commerce Committee and the House last year.

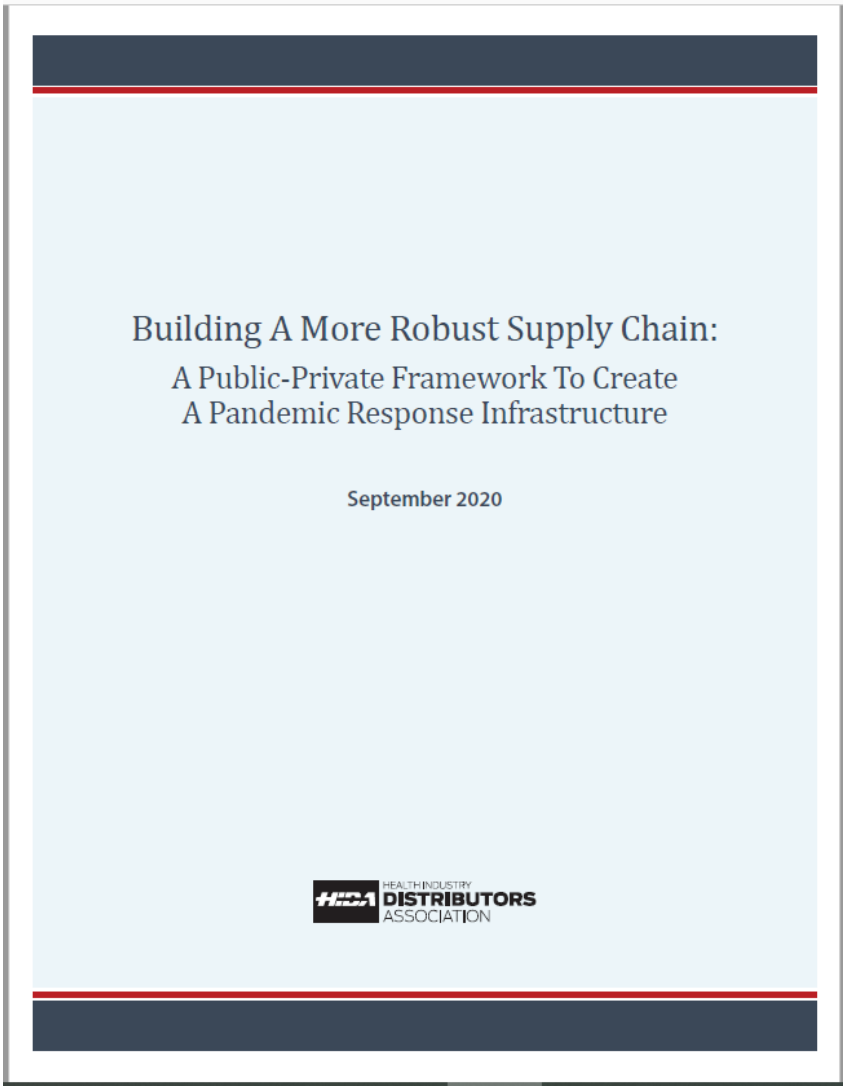
Securing affordable shipping to transport the critical products needed for the COVID-19 response has been a continuing challenge for healthcare distributors. In the fall of 2020, imports of containerized freight were 15% higher than the same period in 2019 due to general restocking, anticipated holiday orders, and pre-orders of PPE prior to the Lunar New Year holiday in Asia. This increased volume of imported goods has created ongoing shortages of shipping capacity by sea, air, and land. To address this problem, HIDA and its members are collaborating with federal partners on ways to prioritize PPE and other critical supply shipments at U.S. ports.

Throughout this pandemic, America's medical products distributors have collaborated with the federal government as trusted partners. Every day, our distributors are using their existing infrastructure to reliably deliver essential medical supplies the last mile into the hands of providers. During the first three quarters of 2020, HIDA members distributed more than 90 billion units of pandemic-related supplies – including more than 39 billion units of PPE.

Our nation's more than 200 medical products distribution companies provide logistics expertise essential to handling 650 million orders every year. Our vast distribution network reaches provider locations across all care settings. This includes 6,000 hospitals, 15,600 nursing homes, 28,900 assisted living facilities, 12,200 home health agencies, 267,000 laboratories, and 230,000 physician offices and clinics.

HIDA appreciates the important work being done in your committee, and we look forward to working with you on long-term policy solutions. If you have any questions or need additional information, please reach out to HIDA's Vice President of Government Affairs, Linda Rouse O'Neill at Rouse@HIDA.org.

Thank you for your leadership on these issues.


Building A More Robust Supply Chain:
A Public-Private Framework To Create
A Pandemic Response Infrastructure
September 2020
HDA
HEALTH INDUSTRY
DISTRIBUTORS
ASSOCIATION

Executive Summary

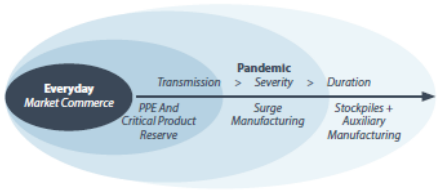
To prepare for the next pandemic event, the U.S. must strengthen its health industry supply chain by creating a pandemic response infrastructure that can both meet an initial, massive surge in demand for key medical products and ramp up quickly to replenish the supply chain continuously over a sustained period of time.

The U.S. healthcare supply chain is strong, but the COVID-19 pandemic demonstrated it needs to be more resilient. Policymakers, manufacturers, group purchasing organizations, and distributors have learned they need to work together to 1) make the supply chain more robust, 2) diversify sourcing, 3) expand and support surge manufacturing capacity, and 4) prevent development of a fraudulent opportunistic marketplace.

The foundation of the pandemic response infrastructure should be a public-private partnership built on four pillars:

- **Forward-Deployed Personal Protective Equipment (PPE) And Critical Product Reserve:** Create stocks of federally funded and controlled pandemic supplies using the 500 commercial distribution locations throughout the U.S., positioning inventory close to healthcare providers and designed to meet their "first-call" needs for 30-60 days until surge manufacturing capability can be mobilized
- **Diversified Surge Manufacturing Capability:** Significantly expand U.S. and nearshored manufacturing capacity to establish a more strategic blend of sources capable of surging to increase volume in 30-60 days to keep customers and stockpiles supplied during a pandemic
- **Sustainable And Replenished Stockpiles:** Require centralized stockpiles to be replenished by the surge manufacturing infrastructure to support state and local government needs during a crisis and serve as a backstop to the commercial supply chain
- **End-User Aligned Supply Chains:** Align distribution channels to categories of end users to avoid surge-driven competition for products that drives up prices and encourages profiteering brokers to enter the marketplace

A Public-Private Framework To Leverage Distributor Logistical Expertise With Federal Planning And Financial Resources



Everyday
Normal Market Commerce
Some Pandemic Capacity

PPE And Critical Product Reserve
Forward Deployed At 500 Distribution Centers Nationwide

Surge Manufacturing
Production Lines To Ramp To Pandemic Quantities

Stockpiles
Support States, Backup For Providers And Distributors

Only the coordinated and combined efforts of manufacturers, distributors and policymakers can build and support the pandemic response infrastructure the U.S. needs.

Lessons Learned

The U.S. healthcare supply chain is strong, but the COVID-19 pandemic demonstrated it needs to be more resilient to respond to a sudden and massive increase in demand for medical products. The country continues to battle a disease that has now stricken two million people and caused more than 180,000 deaths in the U.S. as of August 2020. But manufacturers, distributors, group purchasing organizations, healthcare providers and policymakers have already learned at least four valuable lessons:

1) The supply chain must be more robust
2) Sourcing must be more diversified
3) Surge manufacturing infrastructure must be expanded and supported
4) Supply chains must be aligned to end users

The Supply Chain Must Be More Robust

A Lean Supply Chain Delivery Model That Helps Bend The Cost Curve: During the regular course of business, the U.S. health industry supply chain does an efficient job of sourcing, shipping, storing and delivering thousands of healthcare products for 300,000 hospitals, nursing homes, home health agencies and physician offices. It relies on a just-in-time delivery principles pioneered by Japanese automakers and uses lean supply chain principles to keep manufacturing and inventory costs low. This helps bend the cost curve for healthcare by closely matching supply with demand to drive high efficiency when shipping, storing and managing large amounts of inventory. The model has some excess capacity built in to accommodate fluctuations in demand for products and anticipated events such as seasonal influenza, but significant and sustained changes to either the supply of products or the demand for them can lead to large disruptions.

Unprecedented Surge In Demand: The COVID-19 outbreak created a simultaneous and unprecedented global surge in demand for healthcare supplies. The Pentagon estimates that the demand for N95 respirators soared to 140 million masks during the 90-day peak of the pandemic. That is nearly three times the normal annual consumption of 50 million masks in the U.S. and represented an 11-fold increase in normal three-month usage rates.

A survey conducted by the prominent group purchasing organization Premier at the beginning of the pandemic in March 2020 found that hospitals treating COVID-19 patients were using face shields at more than eight times their usual rate and consuming isolation gowns at five times the usual rate.

The Pentagon estimates that the demand for N95 respirators soared to 140 million masks during the 90-day peak of the pandemic, an 11-fold increase.

Estimated Surge Usage of PPE At Hospitals Treating COVID-19

Supply	Surge Need	Inventory on Hand (Without COVID-19 Patients)	Inventory on Hand (With COVID-19 Patients)
Face Shields	8.6x	3.7 days	3.3 days
Viral Swabs	6x	10 days	9.3 days
Isolation Gowns	5x	4.5 days	2.7 days
Surgical Masks	3x	3.6 days	2 days

Source: https://www.premierinc.com/newsroom/press-releases/premier-inc-survey-as-covid-19-spreads-to-new-hotspots-hospitals-should-prepare-for-up-to-a-17x-surge-in-supply-demand

Typical shipping times for some supplies from an overseas manufacturer to a healthcare provider's doorstep via ocean freight are 30-40 days. This unprecedented surge in demand led to a rapid depletion of available inventory.

Unanticipated Disruption In Supply: At the same time COVID-19-related demand was surging, manufacturing facilities in China, the single largest source of PPE in the world, were being shut down due to the pandemic. Wuhan, the epicenter of the Chinese outbreak and a major source of PPE supplies, was dormant for nearly three months. Other Chinese manufacturing centers were also shuttered for weeks. The result was a significant reduction of supply from the country that produces a major share of the PPE imported by the U.S.

The Need For Greater Reserves: The twin stresses of increased demand and constricted supply demonstrated the need for distinct approaches to day-to-day demands versus those caused by an exceptional event. For everyday needs, the supply chain delivers a large number of products reliably, efficiently and cost-effectively. At the same time, the U.S. also needs a pandemic-oriented infrastructure that combines government planning with the commercial supply chain to create and maintain larger reserve inventories that can mitigate sizable disruptions in the supply chain.

Sourcing Must Be More Diversified

The Supply Chain Is Global: The U.S. health industry supply chain globalized during the last forty years. It did so to take advantage of the development of highly specialized, lower-cost manufacturing expertise outside the U.S. to bend the healthcare cost curve. While the U.S. maintains manufacturing capacity for many types of PPE and medical supplies and, in fact, exports healthcare products to other countries, it also relies on overseas sources for large amounts of its own supplies. Building on long-term relationships with vetted foreign manufacturers, distributors help control costs for healthcare providers while delivering high-quality, FDA-approved supplies and equipment.

Globalization Has Led To Concentrated Sourcing: The globalization of the supply chain also resulted in concentration of the supply manufacturing in several countries. For example, China is the source of 72% of the surgical masks. and 54% of the medical gowns imported to the U.S. But China is not the only example of concentration. Malaysia is the source of 65% of the world's medical gloves.

Malaysia is the source of 65% of the world's medical gloves.

The Disadvantage Of Concentration: As the outbreak of COVID-19 in China demonstrated, one disadvantage of concentration is that the local disruption of a manufacturing center's production capacity can have a global impact. Another disadvantage is that the reliance on transoceanic shipping leaves the U.S. health industry supply chain vulnerable to climate-related events and natural disasters such as hurricanes and earthquakes that can render key ports inoperable for lengthy recovery periods.

The Need For Reshoring And Nearshoring To Provide A More Diversified Mix Of Sourcing: Today's global supply chain exists because it enables healthcare providers to benefit from the economies of scale, specialized manufacturing processes and lower costs of overseas production. Many of the economic benefits of the global supply chain would be significantly diminished if all production were to be reshored to the U.S. or nearshored to the Americas. But the COVID-19 pandemic has demonstrated the logistical and strategic need to rebalance the dependence of the U.S. on distant sources and increase the share of sourcing done closer to home. Achieving this diversity in sourcing will require a significant expansion of U.S. and nearshore manufacturing capacity.

Surge Manufacturing Infrastructure Must Be Expanded And Supported

A Lean Supply Chain Means Limited Additional Manufacturing Capacity: The efficiency of the health industry supply chain includes "flex" capability to meet a surge in demand, but production lines run at near capacity. Adding greater capacity involves a significant investment in new equipment and the time to build or expand existing facilities. It is difficult for manufacturers to invest in capacity knowing that demand quickly dissipates after a public health event. Developing greater manufacturing capacity is a key opportunity for the private and public sectors to partner.

Overseas Sourcing Complicates Rapid Response: Even without the COVID-19 related production shutdowns in China, the steep increase in demand for medical supplies would have significantly stressed the global supply chain due to the lengthy shipping times involved in moving products from manufacturing centers to the U.S. When equipment burn rates increase dramatically, 30-40 day shipping times make it difficult for the supply chain to keep pace.

The Need To Create And Support Surge Capacity In The U.S.: The overall lack of flex capacity in the global supply chain coupled with the complications created by 30-40 day shipping windows point to the strategic need for the U.S. to develop and support production infrastructure that it can ramp up quickly to meet its own surges in demand. The goal is to have surplus capacity that leaves the U.S. less vulnerable to supply disruptions or sudden increases in national and global demand.

When equipment burn rates increase dramatically, 30-40 day shipping times make it difficult for the supply chain to keep pace.

Supply Chains Must Be Aligned To End Users

Increased Demand, Decreased Supply Led To A "Wild West" Marketplace: The combined impact of a drastic increase in demand and constricted supply led to a "Wild West" marketplace as healthcare providers sought far more supplies than usual. In addition, the pandemic brought in new, non-traditional customers for PPE: state governments, charities, and businesses such as grocery store chains and airlines who needed PPE just to provide essential services and stay afloat. All of them competed for the supplies that were available.

Fly-By-Night Brokers Enter The Marketplace: To complicate matters further, as distributors faced the challenge of securing supplies for their current customers, and trying to help additional customers find PPE, new fly-by-night brokers entered the marketplace. Although some of these brokers had noble intentions, most had no expertise or experience in healthcare supply chains. They sourced products of unknown quality from unknown vendors and auctioned those products to the highest bidder. In many cases, brokers did not physically deliver supplies to healthcare providers and, as numerous reports in the media have confirmed, sometimes the product they "sold" did not even exist.

The Need For Supply Chains Aligned To End Users: While there were many contributing factors to the opportunistic marketplace resulting from the pandemic, a recurring theme from providers and states was confusion as to where and how to access supplies. This frequently initiated counterproductive bidding wars among the federal government, state agencies, healthcare providers and other customers for the same supplies and was a major enticement to unqualified, opportunistic brokers to enter the market. A comprehensive preparedness system should align end users to specific supply chains so expectations and communication are clear.

The Response: A Public-Private Framework For U.S. Pandemic Preparedness And Response

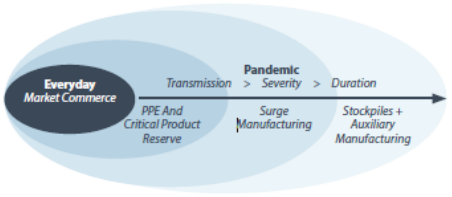
The U.S. needs a national strategy that builds on the lessons learned from the COVID-19 pandemic. We must make available and continuously replenish medical products to satisfy massive, sustained demand from healthcare providers, consumers, first responders, states and essential workers.

This strategy must support, not supplant, the commercial supply chain. Planning should leverage private infrastructure to develop a "whole supply chain" effort. We must coordinate every global and domestic manufacturing source, medical distributor and distribution center in the U.S. to contribute in partnership with government agencies and planners before and during a pandemic.

This infrastructure would feature four components:

1) A forward-deployed PPE and Critical Product Reserve
2) Diversified surge manufacturing capability
3) Sustainable and replenished stockpiles
4) End-user aligned supply chains

A Public-Private Framework To Leverage Distributor Logistical Expertise With Federal Planning And Financial Resources



Everyday
Normal Market Commerce
Some Pandemic Capacity

PPE And Critical Product Reserve
Forward Deployed At 500 Distribution Centers Nationwide

Surge Manufacturing
Production Lines To Ramp To Pandemic Quantities

Stockpiles
Support States, Backup For Providers And Distributors

Forward-Deployed PPE And Critical Product Reserve

The First Line Of Defense: The first line of defense against a future pandemic should include forward-deployed stocks of federally funded and controlled pandemic supplies in up to 500 commercial distribution locations throughout the U.S., positioning inventory close to every provider customer. Pandemic demand rises rapidly across the country and stresses the supply chain from the outset. By instinct and design, healthcare providers make their first calls for additional supplies to the distributors with whom they have long-term, proven relationships.

Forward-Deployed PPE And Critical Product Reserve Using Commercial Distribution Centers To Meet 30-60 Day "First Call" Needs

A 30-60 Day Buffer: The reserve would serve as an important buffer for Strategic National Stockpile supplies and allow sufficient time for surge manufacturing facilities (described below) to come online. While the exact amount and types of supplies would be determined by government planners in coordination with commercial market representatives, the goal would be to have 30-60 pandemic-level days of key supplies in the reserve. This would meet the most immediate needs of healthcare providers during a pandemic. Contract stipulations could include appropriate rotation to manage expiration dates, data linkages, and replenishment, among other terms, similar to the arrangements many states and healthcare providers currently have with distributors.

Products In The Reserve: While PPE would be at the core of the reserve, it should include all critical products needed during a pandemic response such as needles and syringes, infection prevention products, testing products, respiratory products, and IV solutions. During the current COVID-19 outbreak, distributors have identified 30-40 products for which demand spiked precipitously as the pandemic struck and lengthened.

Reserves Should Meet Needs Of All Healthcare Providers: A single distribution center serves dozens of very large customers and up to thousands of smaller to mid-sized healthcare providers such as physician offices, nursing homes and emergency medical services (EMS), among others. When determining the size of the forward-deployed reserves, planners should take into account that in the case of a pandemic, smaller, non-acute care providers will need PPE that they may not use during the normal operations.

Diversified Surge Manufacturing Capability

A Strategic Mix Of Domestic And Global Sources: As discussed above, cost considerations, the ready supply of raw materials, economies of scale, and other factors have all contributed to the globalization of the supply chain. It would be impractical and cost-prohibitive to attempt to make the U.S. completely self-sufficient for all of its healthcare supply needs. Nevertheless, an important lesson of the COVID-19 pandemic is that the U.S. must certainly have more domestic manufacturing capacity of healthcare supplies to cope with disruptions of the normal supply chain. This requires developing a strategic blend of U.S. manufacturing capability that can surge to meet pandemic-level demand, coupled with the established low-cost, high-volume infrastructure of near-sourced and global sources.

The U.S. must have more domestic manufacturing capacity of healthcare supplies.

Ramping Up Quickly: The logistics, space requirements, and expense of storing much more than 60 days of supplies in a reserve are considerable. The surge production capability that is available, either domestically or overseas, must be able to ramp up production rapidly during the buffer period offered by a reserve. By definition, surge capability involves surplus production capacity either in the form of well-maintained but underutilized production lines or facilities that can be easily and quickly converted to produce high-demand products.

New Incentives For Surge Production: The development of surge production capacity will require programs that make it economically feasible for manufacturers to invest in and maintain physical plant that will be optimized only in times of crisis. This would require an array of government funding, grants and incentives that could include financing the expansion of existing U.S. plants, purchasing additional production equipment-and guaranteeing above-market production/source and raw materials to activate in a pandemic. In addition, capacity agreements between the Strategic National Stockpile and manufacturers can be the foundation for federal stockpiles, which would, in turn, create a higher level of production on a regular basis to support investment in additional production capacity.

Supporting Sustainable Levels Of Production And Sourcing: The strongest approach would be to procure and manage specified amounts of equipment while investing in manufacturing capacity (plants, machinery, raw materials) to ensure that these inventory levels can be continuously replenished during a pandemic. Planners should take into account both strategic and economic considerations when deciding where to invest and source products.

Sustainable And Replenished Stockpiles

The Disadvantages Of Static Stockpiles: "Buy and hold" stockpile strategies, such as requiring providers to maintain 90 days' worth of PPE inventory, risk falling short of the massive quantities of supplies required in a pandemic. These requirements are also logistically unworkable. For example, a 90-day supply of high priority products for of a moderately-sized community hospital of 350 beds would require the equivalent of 13-15 tractor trailers of space; there are more than 5,000 community hospitals in the U.S. In a future COVID-19-level event, any government stockpile needs to be replenished by a robust manufacturing/replenishment infrastructure.

A 90-day supply of high-priority products for a 350-bed hospital would require 13-15 tractor trailers of space.

Creating Dynamic National Stockpiles: In addition to the forward-deployed PPE and Critical Product Reserve, the federal government should continue to maintain and expand a select number of centralized stockpiles with the primary goal of supporting state and local government needs during a crisis and serving as a backstop to the commercial supply chain. Even under normal circumstances these stockpiles would be dynamic, with distributors assisting government managers in replenishing and managing products in order to make sure that inventory is up to date and properly handled. During a crisis, the stockpiles would then be replenished, as needed, by the surge manufacturing infrastructure. Stockpiles should include both finished goods and key raw materials to enable surge manufacturing.

End-User Aligned Supply Chains

Distribution Channels Need To Be Specified: The surge-driven competition for products that drove up prices and encouraged profiteering brokers to enter the marketplace during the COVID-19 pandemic was the result, in part, of the entry of non-traditional customers, such as local governments, charities, retailers, restaurants, and grocery stores, into the traditional health industry supply chain. Government planners must strengthen communication and expectations between the Strategic National Stockpile, state agencies and local authorities, as well as with the commercial market. This can be accomplished through the establishment of specified distribution channels aligned by end user.

Alignment By End User: Aligning end users to a specified distribution channel establishes roles and expectations. It reduces confusion. It also allows for better forecasting of demand and allocations. In an emergency, end users should not have to rely on unfamiliar suppliers or processes to access supplies; they should have the ability to use the same source they use every day. Their primary suppliers need to be stocked to supply the first order received and replenished to satisfy future orders.

The End User Matrix: While the focus of HIDA is on its healthcare provider customers, the alignment of supply chains to end users would impact other types of consumers. Designing a pandemic response model in which each supply chain is clear will improve pre-pandemic planning as well as communications and logistics during a crisis. The matrix below provides an example of how supply chains could be classified according to end user type.

Supply Chains Defined By End User

End User		Designated Supply Channel
Healthcare Providers	>>	Medical Products Distributors
Medical Laboratories	>>	Medical/Lab Distributors Scientific Distributors Manufacturers
Public Sector Essential Workers	>>	Government Procurement Healthcare Distributors

Supply Chains Defined By End User, *continued*

End User		Designated Supply Channel
States, Counties, Cities	>>	Government Procurement/Stockpiles Federal Stockpile
Private Sector Essential Workers	>>	General Office Suppliers Industrial Suppliers Healthcare Distributors Retail Suppliers
General Public	>>	Retail and Online

Putting The Framework Into Action: National Legislation Building On The PAHPAI Model

This framework is a public-private partnership that draws on the respective strengths of the federal government and the private sector.

On the public side, before a crisis, the government can set priorities regarding which products to stockpile and where to source them. It can provide the resources for "flex" reserves that can be drawn upon when a crisis suddenly drives up demand. On the private side, distributors are equipped to do what the government is not: handling the logistics of managing and delivering billions of units of PPE and supplies to 300,000 healthcare sites during a time of crisis.

Fortunately, there is already a model for deploying this type of partnership: the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 (PAHPAI).

The PAHPAI Model

Public-Private Partnership Under PAHPAI: PAHPAI addresses all aspects of pandemic preparedness. It establishes a public-private partnership to assist the Assistant Secretary for Preparedness and Response (ASPR) in the Department of Health and Human Services in the development of various preparedness response programs. PAHPAI governs important national response infrastructure such as the Strategic National Stockpile and the Hospital Preparedness Program. It also establishes programs to help hospitals, healthcare facilities, and other public and private sector entities to increase medical surge capacity before, during, and after public health emergencies. In the beginning of 2020, HHS was in the initial stages of pursuing the mandates set out in PAHPAI when the COVID-19 pandemic struck. It was already taking advantage of a productive partnership with HIDA and its members through various work groups.

Work groups bring together experts from public and private partners to analyze market volume, capacity, and viable substitute products.

The Importance Of Work Groups: A key feature of the public-private partnership established in PAHPAI is the creation of work groups. Experts from public and private partners analyze current market volume, capacity, and viable product substitutions/alternatives for specific products. For example, the exchange of information in the work group on needles and syringes provided the Strategic National Stockpile additional insight that the types of needles needed for prevention (mass public health vaccination campaign), are also needed for treatment in hospitals as well as for everyday patient therapies, such as treating diabetes. As a result, HIDA's secured, web-based Mapping Tool provides federal partners with commercial market information on medical distribution centers' aggregated inventory levels of critical products such as needles and IV Solutions.

New Legislation Building On The PAHPAI Model Needed

A More Robust Partnership To Build A More Robust Supply Chain: This framework would require a more comprehensive public-private partnership than is currently provided by PAHPAI. The establishment of a forward-deployed PPE and Critical Product Reserve, maintenance of dynamic national stockpiles and development of surge manufacturing capacity are interconnected issues that would require a commitment of resources and planning time over a multi-year horizon.

The Role Of The Public-Private Partnership: Using the work group model, an ongoing public-private partnership would assist the ASPR and the Strategic National Stockpile to identify 1) how much of which products to have in the distributor-managed reserve, 2) which products and quantities should be in Strategic National Stockpile and 3) how to work with manufacturers to develop additional capacity and production diversification. In addition to identifying specific products to be held in a pandemic response inventory, the work groups would analyze the market capacity for identified products, their impact on patient care, and the complexity involved in developing reserves of each product, such as the availability of raw materials, shelf life, manufacturing complexity and capacity, size of product and lead times.

The Medical Supplies For Pandemics Act Of 2020: H.R. 6531, the Medical Supplies for Pandemics Act of 2020, and its companion in the Senate, S. 3827, provide for the establishment of the public-private framework described in this paper. Both bills were introduced with bi-partisan sponsors and support and HIDA and its members are working for their passage.

The Role Of HIDA

Uniquely Positioned: HIDA is uniquely positioned to assist in the public-private partnership from a data and insights perspective. HIDA represents 100 distribution companies operating 500 medical distribution centers across the country. Additionally, the HIDA Education Foundation has direct relationships with 130 manufacturers, group purchasing organizations, healthcare providers and other stakeholders. These companies make, source and contract for PPE including those that make PPE, testing supplies, diagnostics, infection prevention products such as hand sanitizer, respiratory treatment products as well as other key products needed to deliver vaccines and medical countermeasures.

Experienced Partners: HIDA members are established partners with ASPR and Strategic National Stockpile on pandemic initiatives providing subject matter expertise from our PPE Council and market-based councils to provide deeper insights into market dynamics in end-user segments such as hospitals, labs, physician offices and nursing homes. HIDA has a 20-year history of aggregating distributor sales data for use by industry partners. We also have a best-in-class healthcare informatics partner and deep knowledge of the products and markets. Our ability to ingest, aggregate and report insights from data that can inform ASPR and the managers of the Strategic National Stockpile is proven and unparalleled.

For further information about this report: HIDA@hida.org

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Shipping Challenges Causing PPE Delivery Delays, Cost Increases

In the fall of 2020, imports of containerized freight were 15% higher than the same period in 2019 due to general restocking, anticipated holiday orders, and pre-orders of PPE prior to the Lunar New Year holiday in Asia.[1] The increased volume of goods is creating strains on shipping capacity by sea, air, and land.

Sea — Container Imbalance Adding Weeks To Shipping Times

U.S. imports are growing faster than exports, creating an imbalance of shipping containers in Asia.

2-3 week backlog in Chinese ports due to container shortage[2]

The U.S. is currently receiving twice as many containers as it is sending back to Asia.[2]

4-5 day unloading delay in U.S. ports working with 1/3 fewer workers due to social distancing[3]

Air — Air Freight Capacity Booked Through February, 2021

The drastic decline in commercial air travel has created a shortage of "belly space" for air freight.

Freight capacity on passenger flights **down 67%**[4]

Total global air freight capacity **down 25%**[4]

Cargo flights already booked to capacity **through February, 2021**[5]

Land — Driver Shortage Limiting Delivery Capacity

A dramatic increase in e-commerce is exacerbating the shortage of commercial drivers.

30% increase in e-commerce[7]

Tens of thousands fewer truck drivers due to:

- COVID-19 related retirements
- 30-40% fewer new drivers being licensed
- Increased opportunities to drive locally[8]

Commercial carriers 5% over capacity during holiday season anticipating **7 million late deliveries per day**[9]

1. Supply Chain Dive. Equipment Prices Quadruple As Transpacific Volume Surge Creates Asia Container Shortage. October 15, 2020
2. Container News. Only Slowing Demand Will Sort Asian Container Backlog. November 3, 2020
3. Pacific Merchant Shipping Association. Container Dwell Time in September Among the Highest Ever Reported. October 23, 2020
4. Supply Chain Dive. Capacity Constraints Limit Air Cargo's Ability To Bounce Back. September 30, 2020
5. Supply Chain Dive. Airfreight Rates Climb As Peak Nears. November 9, 2020
6. Wall Street Journal. Covid-19 Vaccine Delivery Will Present Tough Challenge to Cargo Airlines. October 5, 2020
7. Supply Chain Dive. Delays, Surcharges And Returns: Holiday Shipping Headaches Have Just Begun. November 9, 2020
8. Transport Topics. Trucker Pay Increasing As Driver Shortage Grows, Industry Capacity Tightening. October 7, 2020
9. NBC News. FedEx, UPS Face 'Shipageddon' With Potential Shortfall Of 7 Million Packages A Day Over Holiday Season. October 20, 2020

APPENDIX II

QUESTIONS FROM CHAIRMAN BENNIE G. THOMPSON FOR A. NICOLE CLOWERS

Question 1. In January, GAO released a report documenting the Trump administration's inaction and failure to develop a clear and comprehensive vaccine distribution and communication plan. The report concluded that during the final months of the Trump administration, GAO remained "deeply troubled by the lack of sufficient Federal action on critical gaps identified and by the lack of clear plans to address these gaps." Explain how the Trump administration's failure to produce a clear and comprehensive vaccine distribution strategy led to problems with our Nation's ability to vaccinate Americans.

Answer. Informed by our past work reviewing the Federal response to H1N1 flu vaccine and our examination of the Federal efforts to prepare for the allocation, distribution, and administration of COVID–19 vaccines, we reported early on in the pandemic about the importance of having and communicating a National vaccination plan. It is particularly important because of the scope and magnitude of the COVID–19 pandemic. Multiple Federal agencies, commercial partners, and jurisdictions all have roles in implementing any COVID–19 vaccination program, which encompasses identifying priority groups for vaccination as well as allocating, distributing, and administering available vaccine. We found that clear and publicly-available National vaccination plan did not exist.

The lack of a clear and timely National vaccination plan is an obstacle to effective coordination and communication among the Federal agencies, commercial partners, jurisdictions, and providers regarding COVID–19 vaccine distribution and administration. Further, without clear communication, including information about the availability of vaccines, it is difficult to manage public expectations about the progress and availability of vaccines. Clarity to manage public expectations was particularly important with a relatively limited initial vaccine supply.

In September 2020, we recommended that HHS, with the support of DOD, establish a time frame for documenting and sharing a National plan for distributing and administering COVID–19 vaccines that, among other things, outlines an approach for how efforts would be coordinated across Federal agencies and non-Federal entities. To date, this recommendation has not been fully implemented. We maintain doing so would improve the Nation's vaccine distribution and administration efforts.

Question 2. For months, we heard harrowing stories of health care workers having to perform their jobs without adequate protective equipment because the Strategic National Stockpile was not properly maintained and there was no Federal strategy to procure critical supplies, such as N–95 masks. Reports indicate that some hospitals are still rationing N–95 masks for doctors and nurses even though supply has stabilized and stockpiles of these masks are growing. From your work, do you have any thoughts on what the Federal Government do to build trust in the PPE supply chain?

Answer. The COVID–19 Pandemic highlighted the fragility of the U.S. medical supply chain. We and other entities have documented persistent and evolving supply chain challenges throughout the pandemic. Based on our work examining medical supply chain and Federal efforts to manage it, we identified several issues that need Federal attention to improve the supply chain and help Federal, State, territorial, and Tribal stakeholders during the pandemic. Actions at the Federal level can facilitate improvements and build trust in the supply chain for remainder of the pandemic and also trust in preparedness for future pandemics.

Actions needed to improve the medical supply chain and support stakeholders for the remainder of the pandemic include improved communication and coordination. For example, we recommended that the Department of Health and Human Services (HHS), in coordination with the Federal Emergency Management Agency (FEMA) should:

- develop and communicate to stakeholders plans outlining specific Federal Government actions that will be taken to help mitigate supply gaps for the remainder of the COVID–19 pandemic,
- document roles and responsibilities for supply chain management functions transitioning to HHS, and
- work with relevant stakeholders to devise interim solutions to help States enhance their ability to track the status of supply requests and plan for supply needs.

While Federal agencies are taking steps to improve future preparedness by reassessing the medical supply management and strengthening the domestic medical supply, our work has identified areas where additional actions are needed. For example, as HHS develops a strategy to improve the medical supply chain to enhance pandemic preparedness, including re-thinking supply management, we recommended that the agency should regularly engage with Congress and non-Federal stakeholders as it refines and implements its supply chain strategy, including the role of the Strategic National Stockpile.

Question 3. GAO has issued 44 recommendations to improve the Federal response to COVID–19—most originating from GAO's review of the Trump administration's execution of the CARES Act. Our understanding is that when the Biden administration began, only a few of the recommendations had been addressed by the prior administration. As President Biden intensifies efforts to combat COVID–19, which of the recommendations warrant the most urgent action?

Answer. With the publication of our sixth comprehensive report on March 31, 2021, GAO has made 72 recommendations to Federal agencies, and raised 4 matters for Congressional consideration to improve the Federal Government's response efforts.[1]

Throughout our reporting on the Federal response to the COVID–19 pandemic, we have made recommendations that align with key principles that are essential for an effective Federal response. While we maintain that all of the recommendations, if effectively and timely implemented, would improve the Government's public health response, we would highlight the importance of the following:

- *Supply Chain*.—We recommended that HHS in coordination with FEMA document roles and responsibilities for supply chain management functions transitioning to HHS and further develop and communicate to stakeholders plans outlining specific actions the Federal Government will take to help mitigate remaining medical supply gaps. In addition, HHS should work with relevant Federal, State, territorial, and Tribal stakeholders to devise interim solutions, to help States enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID–19 pandemic response.
- *Vaccine Plan*.—We recommend that HHS, with support from the Department of Defense, should establish a time frame for documenting and sharing a National plan for distributing and administering a COVID–19 vaccine and ensure it is consistent with best practices for project planning and scheduling, and outlines an approach for how efforts will be coordinated across Federal agencies and non-Federal entities.
- *Testing Strategy*.—We recommend that HHS develop and make publicly available a comprehensive National COVID–19 testing strategy that incorporates all the characteristics of an effective National strategy.
- *COVID–19 Data*.—To improve COVID–19 data, we recommend that HHS make its different sources of publicly-available COVID–19 data accessible from a centralized internet location and take steps to ensure the complete reporting of race and ethnicity information for recipients of COVID–19 vaccinations. In addition, we recommend HHS immediately establish an expert committee or use an existing one to systematically review and inform the alignment of on-going data collection and reporting standards for key health indicators.
- *Nursing Homes*.—To improve the monitoring and transparency of nursing home vaccination efforts, we recommend that HHS collect data specific to COVID–19 vaccination rates in nursing homes and make these data publicly available. In addition, we recommend that HHS require nursing homes to offer COVID–19 vaccinations to residents and staff and design and implement associated quality measures. HHS, in consultation with CMS and CDC, should develop a strategy to capture more complete data on confirmed COVID–19 cases and deaths in nursing homes retroactively back to January 1, 2020, and to clarify the extent to which nursing homes have reported data before May 8, 2020.

[1] See *https://www.gao.gov/coronavirus/* for our comprehensive reports and other COVID–19-related reports.

For the full list of recommendations in the March CARES Act report and the status of previous recommendations, see *https://files.gao.gov/reports/GAO-21-387/index.html#Recommendations* and *https://files.gao.gov/reports/GAO-21-387/index.html#appendix49.*

Question 4. What recommendations does GAO have for how Federal agencies, like the CDC and FEMA, can construct and maintain robust and equitable COVID–19 vaccination operations?

Answer. Based on our past work, including our review of the Federal response to the H1N1 pandemic, and our review of the on-going COVID–19 pandemic, we have identified a National vaccination plan that is clear, timely, and communicated to the public and data that are complete and accurate as key elements to an effective and equitable COVID–19 vaccination program.

Vaccination Plan.—Coordination and communication among multiple Federal agencies, commercial partners, State and local jurisdictions is critical to effective deployment of vaccines and managing public expectations. While ensuring a continued supply of COVID–19 vaccine is key, it is also critical that all those involved in a vaccination program coordinate and communicate on the allocation, distribution, and administration of vaccines. This includes communicating changes in the expected supply of COVID–19 vaccines. In September 2020, we recommended that HHS, with the support of DOD, establish a time frame for documenting and sharing a National plan for distributing and administering COVID–19 vaccines that, among other things, outlines an approach for how efforts would be coordinated across Federal agencies and non-Federal entities.

Data.—Complete, accurate, and consistent data is needed to inform decision making for the COVID–19 pandemic response, monitor for changes in trends in COVID–19 cases, communicate the status of the pandemic with citizens, and identify areas and populations that are experiencing a disproportionate burden from COVID–19. However, we have found that COVID–19 data being collected by the Federal Government is not complete or is inconsistently reported. Further, data collected and made available by the Centers for Disease Control and Prevention (CDC) suggest a disproportionate burden of COVID–19 cases, hospitalizations, and deaths exists among racial and ethnic minority groups, we found that data reporting is incomplete.

The lack of complete and consistent data limits HHS's and others' ability to prioritize the allocation of health resources in specific geographic areas or among certain populations most affected by the pandemic. Further, lack of data limits the ability of HHS and others to monitor trends in the burden of the pandemic across States and regions, make informed comparisons between such areas, and assess the impact of public health actions to prevent and mitigate the spread of COVID–19.

We have made 4 recommendations to HHS to improve the collection of complete and standardized data on COVID–19 health indicators data. See the Health Care Indicators enclosure *(https://files.gao.gov/reports/GAO-21-387/index.html#appendix2)* and the Nursing Homes enclosure *(https://files.gao.gov/reports/GAO-21-387/index.html#appendix5)* in our March 2021 bi-monthly report. In addition, we have made 5 recommendations to improve the collection of data on race and ethnicity on COVID–19 burden (cases, hospitalizations, and death) and vaccinations administered. See the Health Disparities enclosure in our March 2021 bi-monthly report *(https://files.gao.gov/reports/GAO-21-387/index.html#appendix18)*.

Questions From Chairman Bennie G. Thompson for Crystal R. Watson

Question 1. Many Americans are hearing and seeing a lot of misinformation in their social circles and on social media about vaccines and how they might be causing adverse reactions. Could you speak about vaccine hesitancy and share any recommendations on what can be done to counter such misinformation?

Answer. Response was not received at the time of publication.

Question 2. During this committee's hearing last year, your colleague, Dr. Inglesby, stressed the importance of developing a means to mass manufacture vaccine candidates before they were approved, due to the massive amount of demand in the United States and world-wide. Did the United States do enough to prepare for the mass manufacturing of vaccine candidates over the past year?

Answer. Response was not received at the time of publication.

Question 3. Looking down the road, what can Americans expect to see from the pandemic in the coming months, and what lessons can Congress and the Federal Government take from its experience with COVID–19 to better prepare for future public health threats?

Answer. Response was not received at the time of publication.

QUESTION FROM HONORABLE MICHAEL GUEST FOR CRYSTAL R. WATSON

Question. The University of Mississippi Medical Center is one of only 2 Nationally-designated HHS Centers of Excellence in telehealth. Despite their decades-long history of providing care through technology, they have seen an unprecedented increase in the use of telehealth in the State. More clinicians are using it and patients report a very favorable experience. As we look to the post-pandemic future, what role do you see telehealth playing in addressing public health? How can Government support the continued and expanded use of telehealth to reach rural populations and provide critical specialty care?

Answer. Response was not received at the time of publication.

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Answer. Telehealth can play an important role in addressing public health, specifically in addressing health disparities. Telehealth can increase access to health care in rural and underserved communities and has the potential to reduce health care costs while improving outcomes. Reaching that potential will likely require facilitating utilization beyond the relatively few patients who used telehealth services and providers who furnished telehealth services prior to the COVID–19 pandemic. Medicare Payment Advisory Commission (MedPAC) analysis of calendar year 2014 Medicare claims data showed only 0.2 percent of Medicare Part B fee-for-service beneficiaries (roughly 68,000 individuals) accessed services using telehealth while 10 percent of distant site providers accounted for 69 percent of Medicare telehealth claims.[1] Use expanded greatly during the pandemic. Telehealth accounted for 16 percent of total charges for physician services in April 2020 compared to 0.1 percent in April 2019.[2] Regarding Medicaid, all 50 States and DC reimburse for some type of live telehealth services.[3] Illinois officials reported to the U.S. Government Accountability Office that telehealth represented a very small portion of the overall Medicaid budget—less than $500,000 of the State's $20 billion spending in State fiscal year 2015—and was used primarily to provide psychiatric services.[4]

In order to increase access to telehealth in the future, the Federal Government can do the following:

1. Improve reimbursement for telehealth.—In response to COVID–19, the Centers for Medicare & Medicaid Services (CMS) issued multiple waivers related to telehealth (offering flexibility in geographic location for example) and also granted payment parity between telehealth and in-person care for the Medicare program. Even before the pandemic, providers and patient groups identified inadequate payment for telehealth as a significant barrier to use.[5] Continuing payment parity with in-person care after the pandemic subsides, could be a huge boon for uptake of telehealth.

2. Improve service coverage.—CMS paid for 81 telehealth services in the Medicare program as of 2016.[6] In response to the COVID–19 public health emergency, CMS temporarily added over 140 services to the list of covered telehealth services for Medicare.[7] As recommended by MedPAC, CMS should maintain the

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[1] Medicare Payment Advisory Commission. (2016, June). *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: Author. *http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf*.

[2] Medicare Payment Advisory Commission. (2021, March). *Report to the Congress: Medicare payment policy.* Washington, DC: Author. *http://www.medpac.gov/docs/default-source/reports/mar21__medpac__report__to__the__congress__sec.pdf?sfvrsn=0*.

[3] Center for Connected Health Policy. (2020). *State telehealth laws & reimbursement policies.* West Sacramento, CA: Author. *https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf*.

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[5] GAO, 2017: *https://www.gao.gov/products/gao-17-365*.

[6] GAO, 2017: *https://www.gao.gov/products/gao-17-365*.

[7] MedPAC, 2021: *http://www.medpac.gov/docs/default-source/reports/mar21__medpac__report__to__the__congress__sec.pdf?sfvrsn=0*.

telehealth expansions for a limited duration to gather more evidence about the impact of telehealth on access, quality, and cost, and use that evidence to inform any permanent changes.[8]

3. Increase access to broadband.—Increased access to telehealth requires increased access to high-quality broadband services, especially in rural parts of the country.[9]

[8] MedPAC, 2021: *http://www.medpac.gov/docs/default-source/reports/mar21__medpac__report__to__the__congress__sec.pdf?sfvrsn=0*.

[9] GAO, 2017: *https://www.gao.gov/products/gao-17-365*.