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STATEMENT FOR THE RECORD
On behalf of the
National Emergency Management Association

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"The Role of the Strategic National Stockpile in Pandemic Response"

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Thank you, Chairman Johnson, Ranking Member Peters, and distinguished members of the Committee for allowing me to testify before you today.

I am proud to testify today representing the National Emergency Management Association (NEMA). NEMA represents the state emergency management directors of all 50 states, territories, and the District of Columbia. As Director of the Oregon Office of Emergency Management and on behalf of my colleagues in state emergency management, we thank you for holding this discussion on the use of the Strategic National Stockpile (SNS) during the response to the COVID-19 pandemic.

Oregon represents 190 of the 122,000 COVID-19 deaths nationally, but each one has a profound effect on responders, state and national leadership, and me personally. Our heartfelt condolences go out to those currently diagnosed, recovering from, or bereaving the loss of a loved one during this pandemic.

THE NATION'S RESPONSE

To understand the challenges of the SNS during the response to COVID, we must first examine the evolution of the overall response. During the earliest days of the COVID response, the federal government designated the Department of Health and Human Services (HHS) in the lead role. Many states, on the other hand, opted for more diverse leadership by also giving prominent roles to emergency management, the National Guard, and other state agencies depending on their experience with prior emergency incidents. This led to confusing, conflicting, and incomplete information when state officials attempted to communicate with their federal counterparts.

The process took a dramatic turn on March 13, 2020, when the President utilized Section 501(b) of the Stafford Act to grant Emergency Declarations for all states and territories. Even in early statements by the administration, the intent behind this action was to increase "federal support to the Department of Health and Human Services (HHS) in its role as the lead federal agency for the ongoing COVID-19 pandemic response." The Stafford Act is intentionally flexible to give the President and states the maximum level of discretion in choosing the best combination of federal assets to help respond to a disaster. This action, however, unintentionally deepened the divide between state and federal governments. For a while, HHS remained in the lead federal role while states were now tapping into FEMA's far superior program flexibility and funding opportunities, but as questions arose from state emergency managers, the response from FEMA was often insufficient with referrals to HHS.

Less than a week later, the White House realized the impacts of this discordance and designated FEMA as the lead federal agency. This action helped coalesce the overall response and state/federal coordination. Regardless of how states managed the event to-date, there was now a clear line between the governor's office, state emergency management, and the host of potential FEMA programs.

On March 27, the President signed into law the CARES Act which made available trillions of dollars to aid state and local governments, stimulate the economy, and address the ongoing pandemic. While critical for injecting funds for state and local government response, there were challenges inherent in bringing online additional federal programs that may not normally operate in a disaster environment, including overlapping with the capabilities of existing FEMA programs or exacerbating a morass of

federal requirements and cost-share agreements. These changes to normal disaster funding processes caused accounting nightmares for state and local governments.

Significantly, the determination of cost-share adjustments remains an issue of indecision within the administration. In accepting the Emergency Declarations and subsequent Major Disaster Declarations, nearly every state requested an adjustment to the federal cost share required of FEMA programs from 75 percent to 90 or 100 percent. No state has yet received a response. Meanwhile, the Administration verbally agreed on a non-public conference call to allow the Coronavirus Relief Fund as a source to meet the 25 percent match. One month later, no agency has of yet produced guidance or official communication. This lack of confirmation is one of the primary reasons why the rate of spending against federal programs is not significantly higher. Few states are willing to take the risk of a negative audit against billions of dollars without specific guidance.

The decision on adjusting cost-share should be an easy one. Section 501(b) of the Stafford Act, which the President utilized in the initial declarations, is clear under which circumstances the President may unilaterally declare disasters, saving that authority for only when:

> *"…he determines that an emergency exists for which the primary responsibility for response rests with the United States because the emergency involves a subject area for which, under the Constitution or laws of the United States, the United States exercises exclusive or preeminent responsibility and authority." (Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 93—288, SEC. 501(b))*

Given this clear legislative language, the mere action of utilizing Section 501(b) placed responsibility with the federal government, and a decision on the cost-share adjustment should not be in question.

THE OREGON EXPERIENCE

Oregon's emergency management system, like most other states, is structured around the use of Emergency Support Functions (ESF). These functions leverage subject matter expertise, day-to-day operational capacity and the external relationships of our state agencies. We use the established organizational infrastructure to better position ourselves for emergency response. This allows for continuity across our all-hazards response and helps define roles and responsibilities as we prepare for disasters.

At the federal level, there are fifteen ESFs, each representing a specific functional area and with an assigned lead agency or agencies. Most states, including Oregon, utilized the expertise of ESF 8 which addresses Health and Medical requirements and is led by the Oregon Health Authority. As part of their assigned emergency support function within this structure, we rely on the Oregon Health Authority to maintain responsibility for SNS coordination via direct interface with the federal officials managing the SNS. In turn, Oregon's Public Health staff provide direct connections with local county and tribal health officials as well as their federal counterparts in their day to day work.

Additionally, we consolidated logistics functions to support all ESFs with resource management and distribution across the state. This ensures that subject matter experts remain focused on their core capabilities within the Oregon's emergency management system. In the case of COVID-19, our utilization of ESF-8 personnel helped Oregon's essential medical professionals received the crucial PPE they needed in a timely manner.

INTEGRATING THE SNS

The response to COVID-19 revealed that while the SNS originates in the Public Health field, utilizing the system must involve a broader stakeholder group. In working with my fellow state directors in developing this testimony, many states faced issues accessing the SNS. Successes and challenges, however, varied and seemed to be tied to the level of impact of the pandemic on each state.

Practice Did Not Meet Process. Based on federal guidance and requirements, states and municipalities have traditionally trained to rely on the SNS as the major supplier of resources in a public health emergency. Unfortunately, as the response to COVID-19 continued to escalate, we quickly learned the SNS resources were vastly insufficient. Originally designed to manage pharmaceutical distribution, the movement of masks, gloves, gowns, face shields, vents, and other supplies and equipment proved a daunting task. Furthermore, states had very little visibility into available caches.

As state and municipality pandemic emergency plans are predicated on SNS support in times of crisis, it is critical that there be more transparent support and engagement at the federal level with states on what they can (or cannot) expect and when in the event of incidents of varied escalation - local, state, regional, and national - to allow for improved expectations management and therefore partnership at all levels of government, as well as greater trust from the communities we serve that we can effectively support their public health needs.

Aggregation of Demand. Put simply, states generally did not receive items from the SNS that they needed, or if they did, it was in increments so small that it became insignificant or what was provided was past a functional expiration date. With limited information about the size of equipment caches or their expiration date, states faced further challenges regarding knowing how many PPE items they would need to procure on their own during the early stages of the response.

Some states even indicated they received more equipment through donations or the state-led Emergency Management Assistance Compact (EMAC) than from the SNS. Furthermore, while state officials may appreciate Emergency Use Authorizations (EUA), mid-stream changes to the EUAs and inconsistent guidance proved to be difficult to navigate during a crisis. This led to confusion for both PPE procurement and use of PPE by frontline healthcare professionals.

The Supply Chain. While some states indicated a successful flow of equipment to help bridge the gap of more supply being available, others noted a severe situation whereby the reliance on foreign manufacturing for critical supplies amounts to a national security issue. Large orders of PPE required a few states to charter aircraft to collect materials directly from China. Average delivery time on gowns for one state was 46 days.

Additionally, despite promises of inbound equipment and GPS tracking capabilities, states were often advised of delivery timelines that were not met. In some cases, state staff were called upon to wait at a warehouse for hours for shipments that did not arrive until the next day or even days later. On numerous occasions, supplies were shipped to the wrong locations. Other instances saw states expecting a specific number of "pallets" of equipment only to find one or two boxes on each pallet. Unfortunately, there were also circumstances where the wrong supplies were shipped to states or they were unusable.

Federal Engagement. As states were advised of depleted SNS quantities and that they should begin relying on FEMA to obtain further resources, confusion arose at the state level as they attempted to decipher FEMA versus SNS resources. Here again, the issue and confusion over cost-share became a significant factor as different funding sources had different cost share requirements. The SNS has no cost-share while FEMA funds requires a 25 percent cost share. Requests for 100 percent cost-share on FEMA programs remains unapproved.

As FEMA instituted "Project Airbridge," PPE and other resources started moving by air from the manufacturer to the six major suppliers with FEMA prioritizing the receipt of some of the PPE delivered to the COVID-19 hotspots leaving many states with orders not being filled. This eliminated the ability of state governments to prioritize based on actual need in their jurisdictions. Federal intervention into the procurement process forced states to vie with one another and other entities for limited resources. In essence, a costly and time-consuming bidding war emerged while the virus was at its peak in many states. Later in the process, the federal government did develop a plan to ship PPE directly to some facilities such as nursing homes, but in some cases, this occurred with little or no input from the state.

LIMITATIONS ON TRADITIONAL ASSISTANCE

To meet many of these challenges independently, states would typically utilize EMAC, which is implemented by the state emergency management agencies and allows for an efficient, effective, and coordinated response between states. Since Congress ratified Public Law 104—321 in 1996, EMAC grew to include all 50 states, the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Guam, and the Commonwealth of the Northern Mariana Islands. Never before in the history of EMAC, however, has a single event occurred that affected every member state simultaneously.

During the response, some states were able to share ventilators, PPE, MREs and other resources with states suffering the greatest impacts from COVID-19. EMAC could also be leveraged by states to expand their health care capacity virtually across states lines through telehealth. Mutual aid response to COVID-19 has been somewhat limited as states have needed every resource in their inventory to take care of their own residents.

Early in the response, Oregon sent an incident management team to Washington State which returned with valuable lessons learned we implemented in our own fight against COVID-19. But in later missions, this type of assistance became impractical because states needed the resources themselves, there was a fear of exposing personnel to the virus, and those who deployed to assist other states would need to quarantine for fourteen days upon return.

Since 2016, nearly 30,000 personnel deployed through EMAC. States rely upon one another to fill resource shortfalls during disasters and emergencies. States are now turning their attention to planning for what is predicted to be a busy fire and hurricane season and developing specific guidance for how mutual aid will be safely implemented in a COVID-19 world.

RECOMMENDATIONS

The nation is still in a state of response, and a comprehensive after-action review process will need to integrate all participants of this event. But we do have enough experience and hindsight to begin shaping how the future of the SNS can better serve all customers:

1. **Understand Inventory and Demand.** Before worrying about what states have or maintain, the federal government should assess what they have and where shortfalls exist. States can then integrate these shortfalls into planning assumptions and preparedness actions.

2. **Sort Out the Supply Chain.** Manufacturing of PPE occurs almost exclusively outside the United States which means the supply chain can be compromised, be made of questionable quality, or be delayed to the point of uselessness. Instead of maintaining large stockpiles or an inventory of PPE which must be regularly rotated for efficacy, federal agencies should focus on issues such as supply chain metrics and standing agreements with manufacturers to help meet demand on short notice.

3. **Provide Visibility into the Process.** A secure online portal or other method could take the burden off federal staff and allow states to track their own shipments. Information could also be exchanged with traffic management centers across the country to help route deliveries when transportation infrastructure may be compromised. For example, SNS personnel at the regional level maintained strong lines of communication through a liaison on-site with state and local personnel. As the process dragged on, however, more communication went directly to local hospitals which prevented the state from adequately communicating additional statewide needs to federal partners.

4. **Defense Production Act.** In March of this year, the President signed an Executive Order invoking aspects of the Defense Production Act (DPA) which made available a broad set of authorities to influence domestic industry in the interest of national defense. While the DPA has previously been used with broad success, this invocation appeared to suffer some additional challenges with federal agencies unsure as to how best to coordinate the functions and utilize the Act to its fullest advantage.

5. **Restructure Allocations.** States should be encouraged to establish stockpiles to relieve some demand on the SNS. At a minimum, this should be done regionally, and when possible shared between states through EMAC. Additional discussion will need to occur to determine at what level of demand is reasonable or sustainable for the SNS. It may be useful to consider requiring that states have individual capacity to meet initial surge expectations, with the SNS providing

backup or sustainable capacity in the event of another protracted event like COVID-19. Furthermore, part of the SNS could be apportioned to each state, while leaving the balance to dynamically deploy to meet the most urgent needs nationally.

6. **Find Creative Funding Solutions.** The primary challenge to overcome in recommendations related to states assuming more responsibility for managing SNS caches will be the costs associated with obtaining and rotating equipment and the ability to maintain warehousing capabilities. Congress should resist the urge to require existing grant programs to lurch toward this latest issue and work with states in finding solutions that integrate federal assistance with state expertise and private sector capabilities.

CONCLUSION

Like most of the nation, Oregon remains in active response mode to COVID-19, but we have already begun applying valuable lessons learned in our processes. Cross-discipline and inter-jurisdictional agency partnerships remain crucial in completing our mission to ensure we have the PPE necessary to protect the public. These partnerships across public and private sector proved invaluable as we utilized federal, state, and private industry to strengthen and maintain our supply chain.

Overall, any failure in this system does not rest solely with the SNS. Conflicting information on procurement between the states and federal government on availability and prioritization led to utilization of the Defense Production Act and ultimately an unhelpful bidding war between the federal government and states with FEMA given priority by vendors. Challenges of "who's in charge?" of the response created broken communication chains and processes. The supply chain for PPE relies too heavily on foreign entities and lacks transparency to state emergency managers. Finally, there was a lack of expectations management for what the SNS could or could not do for officials trying to manage a complicated event within their state or community. Moving forward, addressing these interrelated issues will allow for a more sustainable and flexible response system through which states utilize the SNS efficiently in times of critical need.