

Federal Government's Procurement and Distribution Strategies in Response to the COVID-19 Pandemic

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Introduction

Good morning, Chairman Johnson, Ranking Member Peters, and distinguished Members of the Committee. My name is Pete Gaynor, and I am the Administrator of the Federal Emergency Management Agency (FEMA). I am joined today by my colleague and commander of the Supply Chain Task Stabilization Task Force, Rear Admiral John Polowczyk, as well as Admiral Brett Giroir, Assistant Secretary for Health, from US Department of Health and Human Services. Thank you for the opportunity to discuss FEMA's response and the actions underway to protect the American people during the coronavirus (COVID-19) pandemic, as well as the Agency's ongoing engagement with the emergency management community to enhance disaster preparedness within a COVID-19 environment.

For the first time in the United States' history, there are 57 concurrent Major Disaster Declarations—at least one in every single state, 5 territories, the Seminole Tribe of Florida, and the District of Columbia. From islands across two oceans to the major metropolitan cities of America, the scale of this historic event has required FEMA to adapt its response practices and workforce posture in order to both respond to COVID-19 and simultaneously maintain mission readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires.

Regardless of the challenges that FEMA continues to confront, the bedrock of our mission remains constant: helping people before, during, and after disasters. Although—and indeed because—COVID-19 has changed our daily lives and the scope of its impact is unprecedented, the Nation is counting on us to accomplish our mission and we will do so in accordance with our core values of compassion, fairness, integrity, and respect.

Since March 13th the start of FEMA's expanded involvement in this unprecedented event, the Agency has obligated \$6.2 billion from the Disaster Relief Fund to provide personal protective equipment (PPE) to our responders nationwide; establish alternative medical facilities; and fund National Guard troops in every state to support response efforts. More than 3,100 FEMA employees are directly supporting these efforts joining over 4,200 U.S. Public Health Service



Commissioned Corps officers, 5,600 Department of Defense (DoD) Title 10 forces, 44,000 National Guard men and women, and the thousands of others from over 40 federal departments and agencies who have brought the full resources of the Federal government to bear. I would like to thank the Members of this Committee for appropriating the resources FEMA needs to meet these complex and historic mission requirements. Today's testimony will offer an overview of FEMA response efforts and strategies for COVID-19, some of the lessons we have learned, and implementable planning considerations as we pivot to prepare for future disasters during a pandemic response.

Overview of FEMA Response

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

Subsequent to the President's emergency declaration, all states, territories, and some federally recognized tribes requested Major Disaster Declarations. To date, all 50 states, five territories, the District of Columbia, and the Seminole Tribe of Florida have been approved for major disaster declarations to assist with additional needs. FEMA is also working directly with 74 tribes under either the nationwide emergency declaration or a major disaster declaration.

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



In Washington, D.C., the National Response Coordination Center (NRCC) transformed into the fulcrum of federal interagency coordination efforts under the Unified Coordination Group (UCG), which is co-chaired by the FEMA Administrator and Robert Kadlec, M.D., HHS's Assistant Secretary for Preparedness and Response. Seven Task Forces were quickly assembled to address top priorities for the pandemic response, with focuses ranging from addressing community testing to supply chain disruptions.

FEMA's ten Regional Offices are on the front lines of the response, to include activation of their respective Regional Response Coordination Centers (RRCC). In support of this Whole-of-Government effort, there have been up to 46,603 personnel from over 40 agencies—such as the DoD, HHS, Centers for Disease Control and Prevention (CDC), Department of Veterans Affairs (VA), U.S. Army Corps of Engineers (USACE), Defense Logistics Agency (DLA), Customs and Border Protection (CBP)—imbedded within the NRCC and dRRCCs to coordinate response and recovery efforts both nationally and at the local level. At its peak, over 40 federal agencies were involved in this coordinated process.

Managing Critical Shortages

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

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

Phase 1: Distributions from HHS' Strategic National Stockpile



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

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

Given the finite number of medical devices such as ventilators in the SNS and the limited capacity of the private sector supply chains to meet the demand, the Federal government adopted a process to manage federal ventilator resources to ship them to the states only in the quantities needed to manage the immediate crisis. As such, ventilators were designated as strategic national assets to be distributed in accordance with immediate need. Ventilator donations from the private sector and federal partners such as the DoD made meaningful contributions to SNS distributions, and while ventilators were low, we were able to fulfill every state's validated request. Due to these efforts, and federally supported innovations within the American
5healthcare community to modify or retool medical devices such as anesthesia machines, we are proud to say that no one who needed a ventilator went without a ventilator.

Decisions on where to allocate these limited medical resources were thoughtfully and deliberately informed by a series of intervening variables and a data-driven approach. Considerations such as the number of cases, deaths, available Intensive Care Unit (ICU) beds, available ventilators, prevalence of vulnerable



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populations, and knowledge of a location's medical infrastructure helped to inform FEMA decision making. A series of influenza models, such as the University of Washington's Institute for Health and Metrics (IHME) Model funded by the Gates Foundation specifically for COVID-19, also played a critical role in helping FEMA allocate medical resources.

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

To address the imbalance between supply and demand for PPE and other medical supplies, the Supply Chain Stabilization Task Force, under the direction of Rear Admiral John Polowczyk, was swiftly assembled by FEMA, HHS, DOD, CBP and other federal partners to address widespread shortfalls amidst the global competition for life-saving equipment.

The task force sources PPE, swabs, ventilators and other critical resources requested by states, tribes and territories, with a special consideration given to supporting healthcare workers on the front line. Other priority groups included first responders and critical infrastructure workers in lifeline industries who are unable to practice social distancing due to the nature of their work. However, to reiterate my earlier testimony, FEMA and the Supply Chain Stabilization Task Force have never intended to be the single source of PPE or medical supplies for any entity.

To efficiently maintain the country's existing medical supply chain infrastructure, FEMA and the Supply Chain Stabilization Task Force have sought to supplement –not supplant –the supply chain through a variety of strategies, including Project Airbridge.

Project Airbridge has expedited the movement of critical supplies from the global market to medical distributors in various locations across the United States (U.S.). FEMA is supporting Project Airbridge by covering the cost to fly supplies into the U.S. from overseas factories. To be clear, the Federal government does not own the content of these flights, but simply facilitates the rapid transportation of these materials to the United States on behalf of the six largest American medical distributors who have partnered with the Supply Chain Task Force. This airbridge cuts the amount of time it takes to send via cargo ship supplies from manufacturers abroad to American cities from months to days. Each flight contains critical PPE (e.g., gloves, gowns, goggles, and masks) in varying quantities. Since March 29th, Project Airbridge has completed over 200 flights with



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additional shipments scheduled, or in transit, for a total of 222 flights.

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

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

The remaining PPE from Project Airbridge is distributed through the companies' regular networks into the broader U.S. supply chain. Prioritization is given to hospitals, health care facilities, and nursing homes around the country. In some cases, the Federal government may purchase some of the supplies upon arrival to provide to states with identified and unmet needs.

This is truly a historic accomplishment by FEMA and its federal partners. The result is a data-informed process that helps FEMA better ensure the right supplies are getting to the right places at the right time to save lives.

Project Airbridge was integral to the federal strategy to manage critical shortages of PPE and other medical supplies by accelerating international deliveries until domestic and foreign manufacturers could increase production to well above pre-COVID-19 levels and standard supply chains could begin to stabilize.

Phase 3: Transition to Expedited Shipping and Increased Manufacturing managed by DLA

Although Project Airbridge was able to fill critical shortages of PPE and other medical supplies, it was never intended to be a permanent component of a



stabilized supply chain. As global production levels continue to increase, FEMA and the Supply Chain Stabilization Task Force have begun transitioning towards traditional and expedited sea lane shipping with cargo ships able to carry considerable volume. Additionally, on May 10th, FEMA's first shipment of N-95 masks arrived by sea lift in the Port of Long Beach, California, with a subsequent delivery of N-95s arriving on May 21st.

As of June 6th, FEMA, HHS, and the private sector combined have coordinated the delivery of approximately 93 million N-95 respirators, 148.9 million surgical masks, 13.9 million face shields, 37.6 million surgical gowns, and over 1 billion gloves. Expansion of the industry is also simultaneously taking place. Manufacturers are enhancing domestic production capacity with additional machinery, and in some cases re-tooling assembly lines to produce new products. As an example of this work, the Food and Drug Administration (FDA) is providing salient information to manufacturers who have produced other products, such as automobiles, on adding production lines or alternative sites for making more ventilators during the COVID-19 public health emergency.

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

Over two months into the emergency declaration, FEMA's role within the federal response to the COVID-19 pandemic is evolving. FEMA and the DoD's Defense Logistics Agency (DLA) have coordinated the transition of PPE procurement from FEMA to the DLA, with FEMA transitioning its contracts and DLA procuring PPE requested by states and tribes. New procurements for COVID-19 will reside with the DLA, which has a robust procurement and distribution capacity and capability. This transition will help FEMA to better prepare and support the upcoming hurricane season and other potential disasters Americans may face. Regardless of FEMA's role in the management and distribution of critical resources, this COVID-19 response effort will continue to be federally supported,



state managed, locally executed, and in this instance, private sector enabled.

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

The Defense Production Act (DPA)

The Defense Production Act (DPA) of 1950, as amended (50 U.S.C. § 4501 et seq.) is an authority the President may use to expand the production of supplies and services from the private sector needed to promote national defense. This course of action includes emergency preparedness and response activities conducted pursuant to Title VI of the Stafford Act, and protection and restoration of critical infrastructure operations. FEMA specifically has relied on the DPA, as delegated, to focus on increasing the production and distribution of ventilators, N-95 masks, and medical countermeasures.

The authority to use the DPA for health and medical resources for COVID-19 was delegated to the Department of Homeland Security (DHS) and HHS in Executive Order 13911, "Delegating Additional Authority under the Defense Production Act with Respect to Health and Medical Resources to Respond to the Spread of COVID-19." This Secretary of Homeland Security delegated its authority to the FEMA Administrator.

In response to the COVID-19 pandemic, FEMA is utilizing DPA authorities to address disruptions in medical and healthcare lifelines necessary for the continuous operation of critical government and business functions which are essential to human health and economic security. The DPA enables FEMA to leverage domestic industry's ability to supply materials and services in support of the national defense. In addition to using the DPA to protect essential health resources and combat materials shortages, the Federal government is also using the DPA to increase domestic manufacturing capabilities. Increasing domestic



manufacturing through the DPA will help to ensure the United States' future preparedness for pandemics is not overly reliant upon the foreign production of medical supplies which, as we have seen, may be vulnerable to supply chain disruptions.

FEMA is the Federal government's lead coordinating agency for DPA activities in response to COVID-19. FEMA has established the Unified Coordination Group (UCG), chaired by me, with leaders from FEMA, the Department of Health and Human Services, CBP, and other federal agencies to review all incoming requests for use of the DPA for COVID-19. Given the scope of COVID-19, the UCG considers and resolves (or elevates to the White House Coronavirus Taskforce, as appropriate) strategic operational and policy decisions.

FEMA's authorities within the DPA are described in Titles I, III, and VII of the Defense Production Act.

DPA Title I -Priorities and Allocations:

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

DPA Title I also provides authority to allocate limited supplies of materials, services, and facilities in the domestic market, which allows the Federal government to control the distribution of scarce, over-taxed health resources. Furthermore, in response to a Presidential Memorandum, "Memorandum on Order Under the Defense Production Act Regarding 3M Company," on April 3, 2020 FEMA issued a DPA order to 3M for 166.5 million respirator masks from its factories in China, South Korea and Singapore, to be delivered from April to July 2020. FEMA is using this rated order to fill state requests for support and to help fill normal supply chains for PPE.



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

Title III –Expansion of Productive Capacity and Supply

Title III of the DPA allows the Federal government to make loans, loan guarantees, and to take other actions to facilitate increased production capabilities needed to maintain, expand, or protect services and materials essential to the national defense. All DPA Title III actions as a result of the CARES Act have been to expand production capacity to support COVID-19 response. To date there have been no loans or loan guarantees made under the DPA.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) allocated \$1 billion for Title III projects related to COVID-19. Title III funds are held in the DPA Fund, managed by the DOD. These funds have been allocated to support increased production capacity and speed of production of critical healthcare resources including N-95 respirators, N-95 filter media, and testing swabs. .

DPA Title VII–Voluntary Agreements with Private Sector Partners:

Based on a finding that COVID-19 presents a direct threat to the national defense and its preparedness programs, FEMA has also initiated efforts under Title VII of the DPA to establish a Section 708 voluntary agreement for the response to COVID-19 and future pandemics. Under Title VII, FEMA plans to enter into the voluntary agreement with private sector manufacturers and distributors of critical healthcare resources necessary in a pandemic. Participants in a voluntary



agreement are granted relief from antitrust laws for actions taken pursuant to a voluntary agreement at the direction of the federal government.

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

Lessons Learned

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

Preservation and Prioritization

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

The BATTELLE Critical Care Decontamination System (CCDS) became another component of the plan to preserve PPE. These units can sterilize compatible N95 respirators using a mobile CONEX box-based Vapor Phase Hydrogen Peroxide (VPHP) generator. It is the subject of an emergency use authorization issued by FDA, with capacity to sterilize 80,000 such respirators daily. The Federal



Government purchased sixty systems and distributed 45 for use nationwide, with five new systems arriving every week. FEMA continues to work with HHS to support their distribution. We hope that Members of Congress will help to communicate the importance of utilizing preservation techniques such as the CCDS with your constituencies.

Rapid Testing for Vulnerable Populations

Given the wide selection of platforms to administer COVID-19 diagnostic testing and the supply chain limitations for the materials needed to support them, FEMA supported HHS efforts to prioritize rapid testing for vulnerable populations such as those found in nursing homes. Prioritizing the limited number of rapid tests for populations with underlying health considerations was key to facilitating a rapid response and the strategic distribution of scarce supplies. COVID-19 diagnostic platforms with longer turnaround times were found to be more appropriate in situations with lower risk of rapid spread and escalation.

In further support of vulnerable populations within nursing homes, FEMA has been coordinating shipments totaling a 14-day supply of personal protective equipment to all 15,400 Medicaid and Medicare-certified nursing homes.

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

As part of our Agency's efforts to support HHS led community-based testing strategies, FEMA continues to support the White House Coronavirus Task Force and the Administration's Testing Blueprint. Beginning in early May, large quantities of testing swabs and transport media began shipping to help increase testing capacity in support of individualized state, territorial, and tribal plans. As of the end of May, FEMA has delivered over 14 million swabs and 10.2 million tubes of transport media. Each state, territory, and tribe will develop its own distribution strategy to align with its testing plan and unique needs. All states received their initial delivery by May 14, and all states and territories will continue to receive weekly distributions of swabs and media through the month of June. Nationally,



partnerships with major retail companies and local independent pharmacies to increase testing access will provide Americans with faster, less invasive, and more convenient testing for under-tested and socially vulnerable communities.

Improving the Ease of Data Sharing with SLTT Partners

An important component of FEMA's data-based decision-making processes has relied upon state, local, tribal, and territorial (SLTT) partners to share critical data elements about the status of hospital capacity, ventilators, and PPE with both HHS and FEMA. This data enables short and long-term strategic decision support on resource allocation, mitigation strategies, health system needs, and coordination of medical countermeasure development and production. The collection and interpretation of this data has largely fallen under the purview of the NRP and Data Analytics Task Force.

Significant effort has gone into gathering and submitting this data. To address challenges in this process and streamline the reporting of information, FEMA encouraged all facilities to utilize the National Health and Safety Network (NHSN) tracking system, which most healthcare facilities already access and use. Although reporting this data through states and FEMA regions remains an option, using NHSN ensures this information gets to our data and analysis team in the most efficient way and that we can receive the facility level data that we need to support decisions. Improving the ease of collecting this data better enables FEMA to make informed decisions about where to send limited supplies and provides context to support the resource requests we receive from our SLTT partners. This data sharing will continue to be of critical importance in FEMA's continued COVID-19 response, as will corresponding cyber-security considerations.

Rumor Control and Myth Busting

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



lawful transactions to distribute these resources. FEMA does not divert any PPE orders to replenish the Strategic National Stockpile.

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

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

Disaster Preparedness in a COVID-19 Environment

COVID-19 is not the last pandemic the American people will face. It is, therefore, imperative that we continue to prepare at all levels of government, within our communities, and across the private sector by learning from our experience with this novel coronavirus. Furthermore, building a culture of preparedness through a Whole-of-America response could become an important component of our ability to most effectively respond to other disasters such as hurricanes or wildfires during a sustained pandemic response.

Operating in overlapping disaster environments will create new intricacies within already complex mission requirements. For example, there will be a new need to evacuate strategic national assets such as ventilators or key pharmaceuticals. Evacuating people within the current COVID-19 environment will present an even larger challenge, and it will likely require the widespread availability of non-congregate sheltering.



Furthermore, COVID-19 may slow down state, territorial, and tribal abilities to conduct damage assessments for disasters such as flooding, severe storms, and hurricanes. Response to other disasters, in turn, can slow down the ability of officials to collect crucial information about COVID-19 cases and stymie their ability to share the critical data needed to combat it. Consequently, there is a potential for a compounded effect that could result in a larger emergency than each disaster would be on its own.

These are just some of the considerations FEMA has accounted for as we pivot to prepare for what could become active hurricane and wildfire seasons.

2020 Hurricane Season Operational Guidance

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

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

FEMA personnel who are currently deployed will be prepared to pivot to support emergent needs. FEMA regions continue to provide technical assistance and coordination for a range of program areas with their respective SLTT partners. FEMA is also well-positioned with thousands of personnel in the field supporting existing operations, thousands more available ready to support emergent disaster



operations, and more personnel joining the Agency through virtual on boarding every two weeks. In order to better adapt plans in this environment and support our partners, FEMA programs will continue to provide assistance to survivors, but many programs may require online or phone registration processes (in lieu of in-person), remote assessments or inspections, and adapted program delivery within impacted areas experiencing localized outbreaks or periods of peak COVID-19 activity. However, when and if SLTT partners are overwhelmed, FEMA is prepared and postured to provide program support, regardless of delivery method.

Conclusion

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

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

Finally, we again express our appreciation to Congress and the President for providing FEMA with the necessary resources to meet very complex mission requirements and conditions. This historic and unprecedented response will continue to require a Whole-of-America effort, and FEMA looks forward to closely coordinating with Congress as we work, together, to protect the health and safety of the American people during the COVID-19 pandemic.

Thank you for this opportunity to testify. We look forward to answering any questions that you may have.

