

**REVIEWING FEDERAL AND STATE PANDEMIC
SUPPLY PREPAREDNESS AND RESPONSE**

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT,
MANAGEMENT,
AND ACCOUNTABILITY

AND THE

SUBCOMMITTEE ON EMERGENCY
PREPAREDNESS,
RESPONSE, AND RECOVERY

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REVIEWING FEDERAL AND STATE PANDEMIC SUPPLY PREPAREDNESS AND RESPONSE

Tuesday, July 14, 2020

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON OVERSIGHT, MANAGEMENT, AND
ACCOUNTABILITY, AND THE
SUBCOMMITTEE ON EMERGENCY PREPAREDNESS, RESPONSE,
AND RECOVERY,
Washington, DC.

The subcommittees met, pursuant to notice, at 12:02 p.m., via Webex, Hon. Xochitl Torres Small [Chairwoman of the Subcommittee on Oversight, Management, and Accountability] presiding.

Present: Representatives Torres Small, Payne, Barragán, Rose, Underwood, Clarke, Thompson, Crenshaw, Higgins, Guest, and Bishop.

Also present: Representative Jackson Lee.

Ms. TORRES SMALL. The joint hearing will come to order. Let me begin by thanking everyone for joining us today. I hope that my colleagues, our witnesses, and viewers are staying healthy and safe.

I want to thank Chairman Payne and Ranking Member King of the Emergency Preparedness, Response, and Recovery Subcommittee for coming together with Ranking Member Crenshaw and me to hold this hearing.

We are here to discuss Federal and State efforts to procure critical supplies in response to the coronavirus pandemic.

First, I want to acknowledge that the Federal Emergency Management Agency, FEMA, which was put in charge of the Federal Government's response, was asked to testify today.

While FEMA is not here today, I understand that Administrator Gaynor plans to appear before the full committee later this month. I am pleased to hear this because it is vital that we work together to address this challenge. I look forward to meeting with Administrator Gaynor in person soon, and hearing what our witnesses have to share today to inform that discussion.

There is no denying that the coronavirus pandemic has presented unparalleled challenges. One of the greatest challenges has been securing adequate testing supplies and personal protective equipment, or PPE, such as gowns, gloves, surgical masks, and N95 respirators.

A surge in global demand for these supplies, most of which are produced overseas, caused severe shortages, especially for those on the front lines.

In response, the Federal Government distributed the limited supplies in the Strategic National Stockpile and expedited PPE shipments by airlift to distributors' existing customers rather than to States directly. This caused States to find their own supplies to distribute to areas with greatest need.

As a result, competition within the United States intensified as States began competing against each other, the Federal Government, and other buyers around the world. This competition for limited resources drove up prices and attracted new brokers into the marketplace that were inexperienced and unreliable.

Buyers with less purchasing power, such as smaller States and rural areas, like those here in the district I serve in New Mexico, had greater difficulty obtaining supplies.

Some States and major hospitals have been able to replenish supplies, but reports of shortages among health care workers, especially those in nursing care settings, still exist.

Demand for supplies is only expected to grow as several States continue to experience rapidly rising rates of new infections and hospitalizations. Public health officials also predict that a second wave of infections will come this fall.

We must also consider the PPE needs of non-health care workers if we want to successfully reopen the economy, which we all do.

Therefore, it is important to take this opportunity to discuss lessons learned from the past 6 months to improve the procurement and distribution of critical supplies in the future.

This includes revisiting the appointment of FEMA as the lead of the Federal response effort in mid-March, more than 6 weeks after the White House Coronavirus Task Force was formed, a delay that unquestionably put the agency at a disadvantage of executing such a formidable task.

FEMA is well-versed in responding to disasters, but it has struggled to procure supplies in the wake of multiple disasters in the past.

In a joint subcommittee hearing last May, we discussed longstanding challenges with FEMA's process for vetting vendors and overseeing disaster contracts awarded by State and local governments.

I am concerned that FEMA, once again, awarded contracts to vendors who could not deliver during the pandemic. In one case, FEMA canceled a \$55 million contract for 10 million N95 respirators after the company, which conducts tactical training and has no history of procuring medical equipment, failed to deliver the masks.

In another case, FEMA warned States not to use testing equipment it acquired under a \$10 million contract because it was believed to be contaminated. The company that produced the equipment was formed just 6 days before FEMA awarded the contract.

I also worry about whether pandemic response activities have already fatigued FEMA's historically understaffed contracting work force, which is concerning since we are only 1 month into the 2020 hurricane season and entering an active wildfire season.

I look forward to hearing from our witnesses today on their views of FEMA's role in leading the Federal response effort and how we can work together to improve the procurement and distribution of critical pandemic supplies.

Thank you again for joining us today.

Since we have a number of Members joining today, I will be vigilant in watching the clock and ask that my colleagues be mindful of the time available for statements and questions.

[The statement of Chairwoman Torres Small follows:]

STATEMENT OF CHAIRWOMAN XOCHITL TORRES SMALL

JULY 14, 2020

We're here to discuss Federal and State efforts to procure critical supplies in response to the coronavirus pandemic. First, I want to acknowledge that the Federal Emergency Management Agency (FEMA), which was put in charge of the Federal Government's response, was asked to testify today.

While FEMA is not here, I understand that Administrator Gaynor plans to appear before the full committee later this month. I look forward to meeting with Administrator Gaynor in person soon, and hearing what our witnesses have to share today to inform that discussion.

There is no denying that the coronavirus pandemic has presented unparalleled challenges. One of the greatest challenges has been securing adequate testing supplies and personal protective equipment—or PPE—such as gowns, gloves, surgical masks, and N95 respirators. A surge in global demand for these supplies—most of which are produced overseas—caused severe shortages, especially for those on the front lines.

In response, the Federal Government distributed the limited supplies in the Strategic National Stockpile, and expedited PPE shipments by airlift to distributors' existing customers rather than to States directly. This caused States to find their own supplies to distribute to areas with greatest need. As a result, competition within the United States intensified as States began competing against each other, the U.S. Government, and other buyers around the world.

The competition for limited resources drove up prices and attracted new brokers into the marketplace that were inexperienced or unreliable. Buyers with less purchasing power, such as smaller States and rural areas like those here in my district in New Mexico, had greater difficulty obtaining supplies. Some States and major hospitals have been able to replenish supplies, but reports of shortages among health care workers—especially those in nursing care settings—still exist.

Demand for supplies is only expected to grow as several States continue to experience rapidly rising rates of new infections and hospitalizations. Public health officials also predict that a second wave of infections will come this fall. We must also consider the PPE needs of non-health care workers if we want to successfully reopen the economy.

Therefore, it is important to take this opportunity to discuss lessons learned from the past 6 months to improve the procurement and distribution of critical supplies in the future. This includes revisiting the appointment of FEMA as the lead of the Federal response effort in mid-March, more than 6 weeks after the White House Coronavirus Task Force was formed—a delay that unquestionably put the agency at a disadvantage of executing such a formidable task.

FEMA is well-versed in responding to disasters, but it has struggled to procure supplies in the wake of multiple disasters in the past. In a joint subcommittee hearing last May, we discussed long-standing challenges with FEMA's process for vetting vendors and overseeing disaster contracts awarded by State and local governments. I'm concerned that FEMA once again awarded contracts to vendors that could not deliver during the pandemic.

In one case, FEMA canceled a \$55 million contract for 10 million N95 respirators after the company—which conducts tactical training and has no history of producing medical equipment—failed to deliver the masks. In another case, FEMA warned States not to use testing equipment it acquired under a \$10 million contract because it was believed to be contaminated. The company that produced the equipment was formed just 6 days before FEMA awarded the contract.

I also worry about whether pandemic response activities have already fatigued FEMA's historically understaffed contracting workforce, which is concerning since we are only 1 month into the 2020 hurricane season and entering an active wildfire

season. I look forward to hearing from our witnesses today on their views of FEMA's role in leading the Federal response effort and how we can improve the procurement and distribution of critical pandemic supplies.

Ms. TORRES SMALL. The Chair now recognizes the Ranking Member of the Subcommittee on Oversight, Management, and Accountability, the gentleman from Texas, Mr. Crenshaw, for an opening statement.

Mr. CRENSHAW. Thank you, Chairwoman Torres Small and Chairman Payne. I am pleased to participate in this hearing today.

Today's hearing is to examine matters related to the management and distribution of medical supplies in response to the pandemic. This topic is of the utmost importance for our country and to each of our States.

My home State of Texas recently experienced an uptick in reported cases, as did 33 other States. Many are holding steady, but only 3 States saw a decline in the number of cases last week.

As we see cases increasing, we must ensure that our health care providers and first responders have the equipment they need to provide treatment while protecting themselves and slowing the spread of the virus.

The size and scope of this response effort is unprecedented. We have not experienced anything like this in the history of our country. Some experts have compared this to the outbreak of the Spanish flu in 1918, but today we are a much more mobile society, and our economy and supply chain are much more interconnected with the world.

While we are using many of the same tools, such as social distancing, some quarantining, many of the supplies that doctors and hospitals use today to combat the virus are not manufactured in the United States.

Because many of our medical supplies and pharmaceuticals are not produced domestically, we are competing with the rest of the world for the supplies we need to treat our people. Countries like China have a stranglehold on our medical supply chain. We must take steps to regain control of the supply chain from the Communist regime. This is especially important during a global pandemic.

To make matters worse, there is evidence that China deliberately misled the world about the extent of the outbreak in that country while hoarding critical medical supplies and decreasing exports to the rest of the world.

If we had known the true number of individuals infected in China, we would have quickly realized that our stockpile of ventilators, N95 respirators, and other medical supplies were not going to be enough to meet the demand and been able to act earlier to meet the projected need.

While we may have lost critical time at the beginning of the pandemic, once we began to understand the potential scope of the outbreak in this country, the administration took steps to increase the availability of necessary supplies.

FEMA was put in charge of distribution of medical supplies rather than HHS because of its logistical capabilities and relationship with State and local emergency managers. FEMA established

Project Airbridge to find medical supplies and quickly get them to where they were needed.

The President used the Defense Production Act to encourage U.S. companies to join the fight against COVID-19 by altering their operations to provide for critical medical supplies.

Ford, GE, and General Motors stepped up to assist with manufacturing ventilators.

3M doubled its production of N95 masks to 100 million a month.

Bauer, a U.S. company that makes hockey equipment, stopped making helmet visors and started producing face shields for medical professionals.

When wearing a cloth face covering became a way of life for millions of Americans, MyPillow began producing masks to meet the demands of Americans' needs.

After it became apparent that hand sanitizer was in short supply, many distillers, like Whitmeyer's in my district in Houston, converted from making alcohol for consumption to producing hand sanitizer.

American companies are not just meeting PPE and medical equipment demand, but looking forward. In a month-and-a-half, Houston's Medistar founder, Monzer Hourani, took his idea for a filter that can kill COVID from an idea to a prototype to a tested and proven concept that kills 99.8 percent of the virus.

These are just a few examples of U.S. companies stepping up to support our country during the crisis. Many other companies have donated portions of their profits to aid in the fight against COVID.

As we continue to learn more about this virus and the best ways to prevent its spread, we must continue to build our stockpile of medical supplies and ensure that our health care providers and first responders have the tools they need. I look forward to hearing from our witnesses today on the best ways to do that.

I yield back.

[The statement of Ranking Member Crenshaw follows:]

STATEMENT OF RANKING MEMBER DAN CRENSHAW

JULY 14, 2020

Thank you, Chairwoman Torres Small and Chairman Payne. I am pleased to participate in this virtual joint hearing today, but I continue to have concerns about hearings not being held in person. A great deal is lost in translation when we are not all together in one room discussing these important issues.

Today's hearing is to examine matters related to the management and distribution of medical supplies in response to the pandemic. This topic is of the utmost importance to our country and to each of our States. My home State of Texas recently experienced an uptick in reported cases—as did 33 other States—others are holding steady, and only 3 States saw declines in the number of cases last week.

As we see cases increasing, we must ensure that our health care providers and first responders have the equipment they need to provide treatment while protecting themselves and slowing the spread of the virus.

The size and scope of this response effort is unprecedented. We have not experienced anything like this in the history of our country. Some experts have compared this to the outbreak of the Spanish flu in 1918. But today, we are a much more mobile society, and our economy and supply chain are much more interconnected with the world. While we are using many of the same tools, such as social distancing and quarantining, many of the supplies that doctors and hospitals use today to combat the virus are not manufactured in the United States.

Because many of our medical supplies and pharmaceuticals are not produced domestically, we are competing with the rest of the world for the supplies we need to treat our people. Countries like China have a stranglehold on our medical supply

chain, and we must take steps to regain control of the supply chain from the communist regime. This is especially important during a global pandemic.

To make matters worse, there is evidence that China deliberately misled the world about the extent of the outbreak in that country while hoarding critical medical supplies and decreasing exports to the rest of the world. Had we known the true number of individuals infected in China, we would have quickly realized that our stockpile of ventilators, N95 respirators, and other medical supplies were not going to be enough to meet the demand and acted earlier to meet the projected need.

While we may have lost critical time at the beginning of this pandemic, once we began to understand the potential scope of the outbreak in this country, the administration took steps to increase the availability of necessary supplies.

FEMA was put in charge of distribution of medical supplies rather than HHS because of its logistical capabilities and relationship with State and local emergency managers. FEMA established Project Airbridge to find medical supplies and quickly get them to where they were needed.

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3M doubled its production of N95 masks to 100 million a month. Bauer, a U.S. company that makes hockey equipment, stopped making helmet visors and started producing face shields for medical professionals. As wearing a cloth face covering became a way of life for millions of Americans, My Pillow began producing masks to meet the demands of American's need.

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As we continue to learn more about this virus and the best ways to prevent its spread, we must continue to build our stockpile of medical supplies and ensure that our health care providers and first responders have the tools they need. I look forward to hearing from our witnesses today on the best ways to do that.

I yield back.

Ms. TORRES SMALL. Thank you, Ranking Member Crenshaw.

I now recognize the Chairman of the Subcommittee on Emergency Preparedness, Response, and Recovery, the gentleman from New Jersey, Mr. Payne, for an opening statement.

Mr. PAYNE. Thank you, Madam Chair. It is an honor and privilege to be with you and my colleagues here today.

First, I would like to say I hope everyone and their loved ones are staying safe and healthy, and my condolences to those who have lost loved ones because of the coronavirus.

I would like to thank Chairwoman Torres Small and Ranking Member Crenshaw of the Oversight, Management, and Accountability Subcommittee for coming together with Ranking Member King and I to hold this hearing.

I would also like to thank the witnesses for being here today to discuss the pandemic and the challenges with supplies and procurement, a topic that is so incredibly important for our country at this moment.

For too many communities, the pandemic is continuing to get worse. The magnitude of this pandemic is devastating.

It didn't have to be this way, but there was a clear lack of leadership, most importantly at the White House itself. The lack of leadership extended to the Federal Government's procurement strategy, and those effects have been felt by States, local governments, and

front-line workers who are trying to contain COVID-19 around the country without the proper PPE or supplies.

Instead of taking proactive steps early on to invoke the Defense Production Act, build up our supply reserves, and initiating a whole-of-Government procurement strategy and quickly getting testing supplies and other vital medical equipment out into communities, President Trump was instead downplaying the threat of this virus and telling the American people that it was under control and was a problem that was going away.

I hope that it is clear now, with more than 3 million cases and well over 130,000 deaths Nation-wide and daily cases on the rise, that the virus was not and is still not under control.

During the pandemic, States have been left to fend for themselves while dealing with a market that was oversubscribed and underregulated. This led to chaos on the front lines with our health care workers having to reuse masks or use trash bags as gowns in an effort to try to protect themselves.

Efforts by the Federal Government to address supply shortages have also been marred with problems. These problems, including lack of coordination, have plagued the entire Federal response. The initial response was disorganized and wasted valuable time that could have been used better to prepare for what was to come.

These problems continue today:

Rear Admiral Polowczyk, head of the Supply Chain Stabilization Task Force, recently testified that the Federal Government still does not have information on the State stockpiles of PPE or other supplies.

Or, Project Airbridge, which has now been retired, but where reports have stated that many States and cities were not aware whether supplies brought into the country through the Project Airbridge initiative were coming into their jurisdictions.

Further, some shipments of PPE that FEMA coordinated to nursing homes around the country were reportedly defective and inefficient supplies.

Finally, Federal Government contracts for supplies were not vetted properly before being awarded. This includes a \$10 million contract to Fillakit for testing supplies that the agency then had to tell States not to use because the supplies were produced in unsanitary conditions.

Given FEMA's history of procurement failures, Congress must conduct rigorous oversight to ensure past problems are fixed going forward. Neglecting to correct these mistakes will result in unnecessary lives lost, an outcome that we all want to avoid.

Getting it right as soon as possible is especially important as there are growing reports of PPE shortages once again as States see a steep increase in new cases.

To explore these topics, I am glad that we have such an esteemed panel of experts here to help shed light on how we can do better in procuring and distributing supplies.

Thank you very much, and I yield back.

[The statement of Chairman Payne follows:]

STATEMENT OF CHAIRMAN DONALD M. PAYNE, JR.

JULY 14, 2020

For too many communities, the pandemic is continuing to get worse. The magnitude of this pandemic is devastating. It didn't have to be this way, but there was a clear lack of leadership, most importantly at the White House itself. This lack of leadership extended to the Federal Government's procurement strategy, and those effects have been felt by States, local governments, and front-line workers who are trying to contain COVID-19 around the country without the proper PPE or supplies.

Instead of taking proactive steps early on to invoke the Defense Production Act, build up our supply reserves, initiating a whole-of-Government procurement strategy, and quickly getting testing supplies and other vital medical equipment out into communities, President Trump was instead downplaying the threat of the virus and telling the American people that it was "under control" and was a "problem that's going to go away."

I hope that it is clear now, with more than 3 million cases and well over 130,000 deaths Nation-wide, and daily cases on the rise, the virus was not, and is still not, under control. During the pandemic, States have been left to fend for themselves while dealing with a market that was oversubscribed and underregulated. This led to chaos on the front lines with our health care workers having to reuse masks or use trash bags as gowns in an effort to try and protect themselves.

Efforts by the Federal Government to address supply shortages have also been marred by problems. These problems, including lack of coordination, have plagued the entire Federal response. The initial response was disorganized and wasted valuable time that could have been used to better prepare for what was to come. These problems continue today:

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Further, the shipments of PPE that FEMA coordinated to nursing homes around the country were defective or an insufficient supply.

Finally, Federal Government contracts for supplies were not vetted properly before being awarded. This includes a \$10 million contract to Fillakit for testing supplies that the agency then had to tell States not to use because the supplies were produced in unsanitary conditions.

Given FEMA's history of procurement failures, Congress must conduct rigorous oversight to ensure past problems are fixed going forward. Neglecting to correct these mistakes will result in unnecessary lives lost—an outcome we all want to avoid. Getting it right as soon as possible is especially important as there are growing reports of PPE shortages once again as States see a steep increase in new cases.

To help explore these topics, I'm glad that we have such an esteemed panel of experts here to help shed light on how we can do better in procuring and distributing supplies.

Ms. TORRES SMALL. Thank you, Chairman Payne.

The Chair now recognizes the Chairman of the full committee, the gentleman from Mississippi, Mr. Thompson, for an opening statement.

Mr. THOMPSON. Thank you very much, Madam Chair.

First of all, let me thank everyone for being here. Like Chairman Payne indicated, I hope all is well.

Mr. Fugate, it is always good seeing you. You have been a stellar person all your public career.

The COVID-19 pandemic has put our Nation in crisis. To date, the United States has reported over 3 million COVID-19 cases and well over 130,000 people have died from complications associated with the virus. Even as States continue to set daily records for infections and new "hotspots" begin to emerge, the Nation's top medical experts and scientists are predicting a second wave of COVID-19 infections.

Obtaining and distributing critical supplies and medical equipment has proven to be among the most important and challenging factors in responding to COVID-19.

The American people are looking to the Federal Government for leadership and support as the Nation navigates these troubling times. The absence of leadership from the White House has resulted in the lack of a clear, coordinated Federal procurement strategy that has caused complications and delays in States getting essential equipment.

For example, President Trump told Governors, “The Federal Government is not supposed to be out there buying vast amounts of items and then shipping; you know, we are not a shipping clerk,” causing panic and chaos in the procurement process and reducing States’ ability to acquire what they need.

In addition, States have to compete not only with each other for these critical supplies, but also with the rest of the world, significantly driving up prices.

When FEMA took a larger role in the Federal response 6 weeks after the pandemic started, its main responsibility was to improve the Nation’s access to these critical supplies through initiatives like the Supply Chain Stabilization Task Force and Project Airbridge; however, it was unrealistic to expect FEMA to come in and manage a full-blown crisis while planning for and responding to natural disasters and to do it with a contracting work force that had been understaffed and overworked in recent years.

FEMA’s initiatives caused confusion. States reported issues with communication surrounding equipment availability and delivery time frames. Just last week, Governor Pritzker of Illinois called Project Airbridge an utter and complete failure in testimony before this committee.

That assessment is unsurprising given the accounts of non-Federal volunteers, led by Jared Kushner, being embedded at FEMA to work on Project Airbridge. Jared Kushner’s actions further contributed to confusion over who was in charge.

While the committee has repeatedly requested more information on Project Airbridge, FEMA has yet to provide the requested documents and information needed for us to do our oversight work.

Though FEMA was the administration’s choice for this mission because of its experience in disaster contracting and logistics, it has had a history of disaster contracting challenges.

Infamous contracting fiascos like the award made to Bronze Star and Tribute during the 2017 hurricane season demonstrate FEMA’s difficulty getting its procurement responsibilities right during the height of disasters.

FEMA still struggles in this area with the agency having to cancel a \$55 million contract with Panthera in May for the company’s failure to deliver any of the N95 masks that the company promised.

The company had no prior experience obtaining medical supplies or equipment and its parent company was bankrupt. Panthera, which is the company, should never have been awarded a contract in the first place.

As COVID-19 cases continue to rise in States across the country, we must learn from our mistakes and adapt the Federal response to better meet the needs of our communities and front-line workers.

There is still time to get FEMA on track with its procurement processes in hopes that the Nation's preparedness posture will be much improved as we continue to battle the growing first wave of COVID-19 and prepare for a possible second wave in the fall.

I am grateful to the witnesses for taking the time to be here today to contribute to this important discussion.

With that, Madam Chair, I yield back the balance of my time.
[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

JULY 14, 2020

The COVID-19 pandemic has put our Nation in crisis. To date, the United States has reported over 3 million COVID-19 cases and well over 130,000 people have died from complications associated with the virus. Even as States continue to set daily records for infections and new "hotspots" begin to emerge, the Nation's top medical experts and scientists are predicting a second wave of COVID-19 infections.

Obtaining and distributing critical supplies and medical equipment has proven to be among the most important and challenging factors in responding to COVID-19. The American people are looking to the Federal Government for leadership and support as the Nation navigates these troubling times.

The absence of leadership from the White House has resulted in the lack of a clear, coordinated Federal procurement strategy that has caused complications and delays in States getting essential equipment. For example, President Trump told Governors "[t]he Federal Government is not supposed to be out there buying vast amounts of items and then shipping. You know, we're not a shipping clerk," causing panic and chaos in the procurement process and reducing States' ability to acquire what they need. In addition, States having to compete not only with each other for these critical supplies, but also with the rest of the world, significantly drove up prices.

When FEMA took a larger role in the Federal response 6 weeks into the pandemic, its main responsibility was to improve the Nation's access to these critical supplies through initiatives like the Supply Chain Stabilization Task Force and Project Airbridge. However, it was unrealistic to expect FEMA to come in and manage a full-blown crisis while planning for and responding to natural disasters, and to do it with a contracting workforce that has been understaffed and overworked in recent years.

FEMA's initiatives caused confusion. States reported issues with communication surrounding equipment availability and delivery time frames. Just last week, Governor Pritzker of Illinois called Project Airbridge an "utter and complete failure" in testimony before this committee. That assessment is unsurprising given the accounts of non-Federal volunteers, led by Jared Kushner, being embedded at FEMA to work on Project Airbridge. Jared Kushner's actions further contributed to confusion over who was in charge.

While the committee has repeatedly requested more information on Project Airbridge, FEMA has yet to provide the requested documents and information needed for us to do our oversight work. Though FEMA was the administration's choice for this mission because of its experience in disaster contracting and logistics, it has had a history of disaster contracting challenges. Infamous contracting fiascos like the awards made to Bronze Star and Tribute during the 2017 hurricane season demonstrate FEMA's difficulty getting its procurement responsibilities right during the height of disasters.

FEMA still struggles in this area, with the agency having to cancel a \$55 million contract with Panthera in May for its failure to deliver any of the N95 masks that the company promised. The company had no prior experience obtaining medical supplies or equipment and its parent company was bankrupt—Panthera should never have been awarded a contract in the first place.

As COVID-19 cases continue to rise in States across the country, we must learn from our mistakes and adapt the Federal response to better meet the needs of our communities and front-line workers.

There is still time to get FEMA on track with its procurement processes in hopes that the Nation's preparedness posture will be much improved as we continue to battle the growing first wave of COVID-19 and prepare for a possible second wave in the fall.

Ms. TORRES SMALL. Thank you, Chairman Thompson.

Other Members of the committee are reminded that under the committee rules, opening statements may be submitted for the record. Members are also reminded that the subcommittees will operate according to the guidelines laid out by the Chairman and Ranking Member in their July 8 colloquy.

I now welcome our panel of witnesses and thank them for joining today.

Our first witness is Mr. Craig Fugate, who served as the FEMA administrator throughout the entirety of the Obama administration. During his tenure, he led the agency for more than 500 Presidentially-declared major disasters and emergencies.

Prior to leading FEMA, Mr. Fugate headed the Florida Division of Emergency Management, where he led the State through many years of intense disasters and hurricanes, and before that he worked in emergency management at the local level in Florida.

Our second witness, Mr. Mark Ghilarducci, serves as the director of the Governor's Office of Emergency Services for the State of California. He was first appointed to the position in July 2013 by Governor Brown and was reappointed by Governor Newsom in January 2019.

Director Ghilarducci, serves as the Governor's Homeland Security Advisor and oversees State-wide public safety, emergency management, emergency communications, and counterterrorism. He has more than 30 years of experience in public safety and government management at the local, State, and Federal levels.

Our final witness, Mr. Chris Currie, is director on the Homeland Security and Justice team at the Government Accountability Office. He leads the agency's work on National preparedness, emergency management, and critical infrastructure protection issues.

Mr. Currie has been with GAO since 2002 and has been the recipient of numerous agency awards, including the Meritorious Service Award in 2008.

Without objection, the witnesses' full statements will be inserted in the record.

I now ask each witness to summarize his statement for 5 minutes, beginning with Mr. Fugate.

STATEMENT OF W. CRAIG FUGATE, SENIOR ADVISOR, BLUE DOT STRATEGIES, AND FORMER ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY

Mr. FUGATE. Thank you, Madam Chair, Chairs, and Ranking Members of the committee.

We can spend a lot of time talking about what goes wrong in these types of responses. I want to introduce some ideas that may be able to minimize these impacts later. It goes back to, in your opening statement, several key issues we have had.

FEMA was brought in late. A lot of this has to do with that FEMA is too often only seen as the agency that responds to Stage 4 natural hazards, even though the Homeland Security Act, as amended, or also known as the Post-Katrina Emergency Management Reform Act, essentially gives the President the authority to use FEMA in any crisis, not just when there is a Stafford Act declaration.

I think this is something that needs to be reinforced. If we are going to utilize FEMA as a crisis agency, that role needs to be further strengthened and defined so that it is not that FEMA takes over.

In fact, I was a little bit disconcerted when they put FEMA in charge of this response. I still felt that CDC and Health and Human Services should have been the lead with FEMA supporting them, just like we supported USAID in the response to the Haiti earthquake and we supported Customs and Border and Health and Human Services family services during the unaccompanied children on the border and as we supported CDC in the Ebola crisis.

FEMA is not just about hurricanes, wildfires, or earthquakes. They are an all-hazard agency. But I think that strengthening that as the Nation's crisis manager would further streamline the Federal response to future crises.

It isn't that FEMA takes over, but FEMA helps many agencies who do not do crisis response full time, as you point out, do not have the relationships with the State emergency management teams, like Director Ghilarducci, and often find themselves struggling in those first days and first weeks to begin that response.

The second part of this is the Stafford Act. Too often I think FEMA is defined by what you can declare under the Stafford Act, and under the Stafford Act, for a major Presidential declaration, Congress has enumerated what would be considered a disaster.

Pandemics are absent. So are cyber attacks. In many cases certain terrorist attacks, unless they involve an explosion or fire, could conceivably be excluded.

I think by amending the Stafford Act, adding pandemics, cyber attacks, and other events to that so we are no longer uncertain about FEMA's role, we could have turned on much of the individual systems [inaudible] dealing with how to provide everything from disaster employment, food stamps, crisis counseling, legal assistance, all things that could have been turned on in that disaster.

The third area that I think we need to address goes back to this whole supply chain. I like to say that efficiency is the enemy of resiliency. What you are seeing in this pandemic in a just-in-time global delivery system has produced very efficient low-cost supplies, particularly in the health care industry.

But what we are seeing in this pandemic is only the tip of what could happen to other industries where we have critical infrastructures for communications, power systems, water supplies, treatment systems across the whole vast definitions of what Homeland Security has defined as critical industries that are dependent upon international global supply chains. That has increased our vulnerability through competition, but also lack of ready access.

I think we need to look at increasing the capabilities of domestic production. This will not be based upon a business model that says we get the best value. It is about creating inefficiencies to build resilience, either through tax credits or purchasing power.

But if you wait until a crisis occurs and then discover that your supply chain that you need for critical infrastructure or supplies is located on the other part of the world and now there are disruptions, either intentional, or competition, or the fact that disasters can occur elsewhere and disrupt our supply chains, we are seeing

with the pandemic how loss of domestic capability and production is actually impacting our ability to respond.

So I think—I don't know, you know, again, as we look at this, just like our defense industry, we don't outsource building our submarines. Why are we outsourcing those supplies that are critical to key infrastructures that we need to have up and running?

I think, again, Congress can, in many cases, influence that through the ability of tax credits, the ability of purchasing power, and [inaudible] relationships.

This gets to, I think, part of the matter about FEMA [inaudible] after this. When you tell FEMA to go find whatever you can find for PPE, you get the results we got.

Thank you, Madam Chair.

[The prepared statement of Mr. Fugate follows:]

PREPARED STATEMENT OF W. CRAIG FUGATE

JULY 14, 2020

Chairs Small and Payne, Ranking Members Crenshaw and King, and Members of the committees, thank you for inviting me to testify today about "Reviewing Federal and State Pandemic Supply Preparedness and Response."

While others will focus on the current response, I want to focus on what we can do differently before the next pandemic or other National-level disaster.

Establish FEMA as the Federal Government's Crisis Manager and providing funding from the Disaster Relief Fund to support FEMA response to non-Stafford Act Disasters.

Background.—While FEMA is most noted for the coordination of Federal disaster response under a Stafford Act Declaration by the President, other events such as COVID-19 show the need to utilize the crisis management tools that FEMA brings to a response. From supporting USAID in the response to the Haiti Earthquake, CDC during the Ebola crisis, or managing the unaccompanied children crisis on the border, FEMA has brought needed capabilities. These responses were managed under the authorities of the Post-Katrina Emergency Management Reform Act of 2006—Title I: National Preparedness and Response—(Sec. 101). Amends the Homeland Security Act of 2002 (the Act) to make extensive revisions to emergency response provisions while keeping the Federal Emergency Management Agency (FEMA) within the Department of Homeland Security (DHS). Sets forth provisions regarding FEMA's mission, which shall include: (1) Leading the Nation's efforts to prepare for, respond to, recover from, and mitigate the risks of, any natural and man-made disaster, including catastrophic incidents; (2) implementing a risk-based, all-hazards-plus strategy for preparedness; and (3) promoting and planning for the protection, security, resiliency, and post-disaster restoration of critical infrastructure and key resources, including cyber and communications assets.

Amend the Stafford Act to add Pandemic to the definitions for a Major Disaster.

Background.—CRS Report for Congress: Would an Influenza Pandemic Qualify as a Major Disaster Under the Stafford Act? October 20, 2008 Edward C. Liu, Legislative Attorney, American Law Division.

Establish a standing Disaster Review Body like the National Transportation Safety Board to review the response to COVID-19 and other major disasters.

Background.—<https://www.healthaffairs.org/doi/10.1377/hblog20180720.1685-27/full>.

Review all critical National infrastructures for supply chain dependencies outside of the United States and determine whether to provide incentives to increase reserves and domestic manufacturing capabilities.

Background.—Efficiency is the enemy of resiliency. Just-in-time delivery systems and outsourced global supply chains has reduced the cost of many goods and services required for our Nation's infrastructure. However, that has also created vulnerabilities in global crises and disruptions to the supply chains. I would focus on the DHS's definitions of Critical Infrastructure Sectors. <https://www.cisa.gov/critical-infrastructure-sectors>.

Ms. TORRES SMALL. I now recognize Mr. Ghilarducci to summarize his statement for 5 minutes.

**STATEMENT OF MARK GHILARDUCCI, DIRECTOR, OFFICE OF
EMERGENCY SERVICES, GOVERNOR'S OFFICE, CALIFORNIA**

Mr. GHILARDUCCI. Well, good morning, Chairman Payne, Chairwoman Torres Small, Ranking Members King and Crenshaw, and Members of the subcommittee. Thank you for inviting me to testify on the Federal Government's personal protective equipment procurement and distribution.

I also discuss the State of California's response to the COVID-19 global pandemic, particularly the State's strategy for emergency procurement and distribution of life-saving PPE, which has been the largest disaster logistics and commodity distribution operation in the history of the State of California.

On behalf of the State of California, I want to begin by extending my sincere gratitude to all of the Federal agencies who have provided coordination, assistance, and funding in helping California respond to the COVID-19 pandemic.

Along with most of the Nation and the world, California has been severely impacted by the COVID-19 pandemic. As of July 13, the State has 336,508 cases and has tragically lost 7,087 lives to the disease.

However, California began dealing with indirect effects of this pandemic long before any other State, in January, when the State coordinated and accepted flights of repatriated citizens from China.

Shortly after, California coordinated with the U.S. Department of Health and Human Services in an unprecedented operation to safely disembark and quarantine all passengers on the Grand Princess cruise ship.

In January 2020, as the COVID caused the entire city of Wuhan in the Hubei Province in China to quarantine, California rose to meet the need when the State Department began repatriation flights to bring American citizens home. Cal OES activated the State Operations Center and worked with the State Department, Department of Defense, Department of Homeland Security, Department of Health and Human Services, and other Federal agencies and State agencies to assist in the coordination of these missions.

On February 1, there were 6 confirmed positive COVID-19 cases in California. By late February, the State had enhanced its capabilities dedicated to COVID response after the first case of community transmission in the State.

By March 4, the Governor declared a state of emergency in anticipation of increasing rates of the COVID-19 infection. At that time, resource requests for PPE were accelerating, prompting the State Operations Center to begin distributing the 21 million N95 masks and 1 million surgical masks we had in our reserves.

On March 6, Cal OES received notification from the U.S. Department of Health and Human Services that the Grand Princess cruise ship was heading to California from Hawaii. The Grand Princess, which normally ported in San Francisco, initially went to Mexico before coming back to California to offload and pick up passengers. It then set sail to Hawaii.

There were an unknown number of sick people on the ship. California supported the CDC, Health and Human Services, and ASPR with several high-profile missions to the Grand Princess while still at sea, including transporting medical staff and necessary PPE,

testing of staff and passengers, delivery of essential medications to passengers, and several evacuations of sick individuals.

This was a major operation that demanded California provide incident management support and large quantities of logistical support to Health and Human Services, the lead Federal agency, including medical personnel and PPE.

At this time our partners at FEMA Region IX were very responsive and provided as much assistance as possible given they were not yet the lead Federal agency. Following an extensive effort involving multiple levels of government, the State developed a plan with the ship to berth at the Port of Oakland. The first passengers disembarked on March 9 and the last passengers disembarked on March 16 in a meticulous process to protect the health of everyone involved.

Passengers, including Californians, other U.S. citizens, and foreign nationals, were transported to and quarantined at Travis Air Force Base, Marine Corps Air Station Miramar, and other alternate care sites established by the State to ensure that no COVID-19 spread in the community before they returned home.

During the repatriation in the Grand Princess operation it quickly became clear that Health and Human Services had trouble with maintaining the tactical scope and scale to respond to the issues that arose during these missions. All deployed staff from Health and Human Services had specific purposes and were inflexible or unable to respond to evolving needs in the State in a timely way for challenges we were addressing.

Recently we have heard that the Federal Government has considered placing HHS back in the lead coordination role for this pandemic. This is concerning as we believe it would unnecessarily slow down and complicate the National response that is under way.

FEMA's infrastructure and experience leading operations across the entire Federal family and assisting States has actually been incredibly valuable and should be continued.

Overall, the most significant challenge of the Federal Government's response to the pandemic has been the lack of a coordinated, centralized approach to secure, obtain, and distribute PPE.

The Federal Government's response to the on-going PPE crisis should be characterized as challenging or really unsuccessful. In a global pandemic, with world-wide competition for critical life-saving assets, a National strategy to leverage Federal buying power and consolidate asset acquisition and distribution was nonexistent.

In fact, every State—

Ms. TORRES SMALL. Mr. Ghilarducci, I apologize. Your time has expired. If you can just summarize the rest of your comments.

Mr. GHILARDUCCI. So the bottom line is that overall the efforts of obtaining and coordinating on a National scale, since we are talking about PPE and the need to get it in a timely fashion, setting up a competition where States were competing with each other and States were competing with the Federal Government for limited commodities that were absolutely necessary for life saving is not a position that we should be in as a State or as a country.

This is problematic. Supply chains and having a capacity to have domestic supplies enhances domestic supplies. When you don't have those capabilities, implementing the Defense Production Act

in a real way to be able to adequately and rapidly provide PPE is critical. In this case that did not happen.

[The prepared statement of Mr. Ghilarducci follows:]

PREPARED STATEMENT OF MARK GHILARUCCI

TUESDAY, JULY 14, 2020

Chairman Payne, Chairwoman Torres Small, Ranking Members King and Crenshaw, and Members of the subcommittees, thank you for inviting me to testify on the Federal Government's personal protective equipment (PPE) procurement and distribution during the COVID-19 pandemic.

Along with most of the Nation and the world, California has been severely impacted by the COVID-19 pandemic. As of July 11, the State has 312,344 cases and has tragically lost 6,945 lives to COVID-19. However, California began dealing with indirect effects of this pandemic long before any other State—since January, when the State coordinated and accepted flights of repatriated citizens from China.

REPATRIATION FLIGHTS TO CALIFORNIA

In January 2020, as COVID-19 caused the entire city of Wuhan in the Hubei Province of China to quarantine, the State of California was notified by the U.S. State Department (DOS) of the need to activate the pre-established Repatriation Plan. California rose to meet the need when the DOS began repatriation flights to bring American citizens home. The California Governor's Office of Emergency Services (Cal OES) activated the State Operations Center (SOC) and worked with the DOS, Department of Defense, U.S. Department of Homeland Security, U.S. Department of Health and Human Services (HHS), and other Federal and State agencies to assist and coordinate these missions.

Repatriation flights landed at March Air Reserve Base, Travis Air Force Base, and Marine Corps Air Station Miramar in late January and early February. California served as the gateway for thousands of Americans to return home safely. This required close coordination on the State's part with not only multiple Federal and State agencies and departments, but also local fire and law enforcement, public health, and emergency management to provide the necessary logistical needs, such as appropriate sheltering and medical support for the repatriated citizens who were placed under quarantine upon arrival. As well, the Federal Government issued travel advisories for China, which resulted in tens of thousands of travelers immediately passing through or traveling to San Francisco, Los Angeles, and San Diego airports.

On February 1, there were 6 confirmed positive COVID-19 cases in California. Throughout the month of February, the California Department of Public Health, in conjunction with the California Health and Human Services Agency, continued to monitor cases and work with local public health departments on contact tracing in the State. In late February, the State enhanced its capabilities dedicated to COVID-19 response after the first case of community transmission in the State.

On March 4, the Governor declared a State of Emergency to build on the work already under way by the State and engage all levels of government in anticipation of higher rates of COVID-19 infection. At that time, resource requests for PPE were accelerating, prompting the SOC to begin distributing the 21 million N95 masks and 1 million surgical masks from its reserves.

GRAND PRINCESS RESPONSE

On March 6, Cal OES received notification from HHS that the Grand Princess cruise ship was heading to California from Hawaii. The Grand Princess, normally ported in San Francisco, initially went to Mexico before coming back to California to offload and pick up passengers. It then set sail to Hawaii. There were an unknown number of sick people on the ship. California supported the Centers for Disease Control and Prevention (CDC) and the HHS Office of Assistant Secretary of Preparedness and Response (ASPR) with several high-profile missions to the Grand Princess while still at sea. This included transporting medical staff and necessary PPE, testing of staff and passengers, delivery of essential medications for passengers, and several evacuations of sick individuals.

This was a major operation that demanded California provide large quantities of logistical support to HHS, the lead Federal agency, including medical personnel and PPE. At this time, our partners at the Federal Emergency Management Agency (FEMA) Region IX were very responsive and provided as much assistance as possible, given they were not the lead Federal agency.

Following an extensive effort involving multiple levels of government, the State developed a plan for the ship to berth at the Port of Oakland. The plan ensured the passengers, 21 of which had tested positive for COVID-19, could disembark safely and receive medical treatment. With HHS as the lead, California provided support by establishing a dockside medical receiving and processing capability. The first passengers disembarked on March 9, and the last passengers disembarked on March 16, in a meticulous process to protect the health of everyone involved. Passengers, including Californians, other U.S. citizens, and foreign nationals, were transported to, and quarantined at, Travis Air Force Base, Marine Corps Air Station Miramar and at other alternate care sites established by the State to ensure there was no COVID-19 spread in the community before they returned home.

COORDINATION WITH THE FEDERAL GOVERNMENT

In January, as discussed above, the lead Federal agency during the repatriation and Grand Princess mission was HHS. It quickly became clear that HHS had trouble with maintaining the tactical ability to respond to the issues that arose during those missions. All deployed staff from HHS had specific purposes and were inflexible and/or unable to respond to evolving needs of the State in the challenges we were addressing.

Once the pandemic spread across the Nation, it was clear there was no strategic initiative or coordinated plan from HHS, the White House, or the CDC. Outside of the CDC, there was very little Federal guidance provided to the States. Regarding PPE, specifically, there was one brief mention of cost eligibility provided in a FEMA fact sheet on emergency protective measures. At the same time, our partners at FEMA Region IX, who had embedded at the SOC along with HHS, worked to adjudicate and provide critical technical assistance where possible, including those related to Federal resources, the State's procurement, and ultimately FEMA's distribution of PPE.

On March 13, the President issued an Emergency Declaration, and on March 19, the Governor issued a State-wide stay-at-home order, requiring all non-essential activity to cease. On March 22, the Governor requested, and the President approved, a Major Disaster Declaration for California for Direct Federal Assistance, Emergency Protective Measures, and Public Assistance. This action initiated the switch in lead Federal agency from HHS to FEMA.

Given the complexity of the situation and how late into the response they took over Federal responsibility, FEMA was both challenged and worked to be incredibly responsive. FEMA did the best they could to organize information and operations to assist our State. FEMA Region IX is still embedded in the SOC and has played a critical role in the State's Logistics and Commodity Movement Task Force and in communicating across the entire Federal family. Particularly, the FEMA Region IX administrator and liaison officers have been highly communicative and supportive, especially in moving the State's requests through the relevant Federal departments.

FEDERAL RESOURCE PROCUREMENT AND DISTRIBUTION

Strategic National Stockpile

The same week as the Major Disaster Declaration on March 22, following requests by the State to HHS for deployment of the Strategic National Stockpile (SNS), California received its initial allotment of PPE from the SNS. It quickly became apparent that the Federal Government had not effectively maintained the SNS. Although the State had planned on a complete and fully functional SNS, HHS provided the State with only a percentage of PPE necessary to keep health care workers and front-line workers safe. Notably, the SNS allocation to California was absent any ventilators to treat those affected most seriously by COVID-19. Of the SNS resources that were received, many of the N95 respirators were expired. In the end, California only received 75 percent of the total SNS allocation that it had expected and planned for. The separate SNS allocation dedicated specifically to the county of Los Angeles included a small number of ventilators, and unfortunately, all of the ventilators were inoperable and required refurbishment by the State, delaying the deployment of these critical resources.

California received only 75 percent of its allotment from the SNS, comprising:

- N95 Masks.—20 million
- Surgical Masks.—10 million
- Face Shields.—600,000
- Surgical Gowns.—600,000
- Coveralls.—100,000
- Gloves.—600,000
- Goggles.—300,000.

Federal Testing Supply Distribution

In addition to PPE, California has received the following monthly allocation of testing supplies from the Federal Government:

	Swabs	Transport Media
May	1.2 million	900,000
June	1.5 million	900,000
Total	2.7 million	1.8 million

California has requested 1.2 million swabs and 1.2 million units of media for the month of July, and we expect to receive these amounts based on our communications with HHS. Additionally, HHS provides a weekly allocation of Abbot ID Now test kits to the State. Our initial allocation was 2,400 tests per week, although recently the amount has increased. On July 9, California received word that the Federal Government is providing us with an additional 50 Abbott ID Now devices and 15,000 tests to address current surge needs. This is a huge one-time increase in rapid point-of-care testing for the State and will be immensely helpful.

Like Federally-distributed PPE, however, testing supplies and processes have also had significant issues.—Initially, there was much confusion and discoordination with both distribution of testing supplies and the roll-out of the testing sites across the country. Although California was actively working to implement a State-wide testing process, HHS had an inflexible approach requiring the State to follow a “one size fits all” strategy, which was very problematic. Nevertheless, the State adjusted to meet HHS requirements. In the end, HHS changed course and allowed the State to implement their own system. This simply cost valuable time and much unnecessary strain.

As well, early on, there were complexities with getting appropriate and sufficient testing supplies, to include swabs and media. The ability to get testing supplies in a timely fashion was inconsistent and on more than one occasion, the testing supplies provided were the wrong ones. Currently, about 760,000 units of the viral transport media manufactured by Fillakit are in quarantine in one of our State warehouses due to potential quality assurance issues. FEMA is aware of this issue and is working hard with the U.S. Food and Drug Administration (FDA) to resolve the problem.

On July 8, to address a recent spike in positive cases throughout the State, California submitted additional requests for testing supplies to the Federal Government, including:

- Roche Cobas 6,800/8,800 test reagents, to support 30,000 tests per day.
- Roche extraction reagents for MP96, Compact, and LC 2.0, to support 20,000 tests per day between the 3 machine types.
- 50 Abbott ID Now machines to place in prisons/jails for symptomatic testing and 15,000 cartridges per day to support this testing prison/jail testing over the next 6 months and in Imperial County’s 2 hospitals.
- 100 Cepheid GeneXpert machines to place in skilled nursing facilities and in Imperial County’s El Centro Hospital, and 480,000 cartridges to support skilled nursing facility testing over the next 6 months.
- Qiagen RNA extraction reagents, to support 15,000 tests per day.
- Additional 200 BD Max supplies boxes per week, to support Imperial Public Health Lab.
- Biomérieux EasyMAG RNA extraction kits, to support 30,000 reactions per week.
- 29 Hologic Panther Fusions machines to place in 29 public health labs, reagents to support 20,000 tests per day, and Hologic TMA reagents to support 15,000 tests.

Federal Medical Personnel

Obtaining consistent Federal medical resources has been challenging as well. This is more understandable, given the Nation-wide impact from the pandemic and the need for resources by all States. However, the lack of a strategic, coordinated approach to resource allocation has been problematic. As well, the reluctance to utilize or commit DOD assets and facilities for the long term has been a challenge. The inability to secure Federal resources for more than short durations results in a “revolving door” approach of assets, requiring the State to continually shop for resources during a pandemic that has exhausted resources. Beyond the request for Federal assets, California has actively pursued contracts with private medical providers and early on, launched a State-wide Health Corps initiative. Through the

Health Corps, the State leverages available medical professionals and deploys them strategically to locations throughout the State.

More recently, on July 6, California requested an additional 190 professional medical staff from the Federal Government to deploy from July 15 to September 15. These personnel will assist California's efforts in Imperial County to address the on-going surge at the U.S.-Mexico border, as well as intensive care unit (ICU) capability throughout the State. This request included:

MD Intensivists— ICU and ER	Mid-Level Providers (Nurse Practitioners/ Physicians Assistants)	Respiratory Therapists	ICU/ER Critical Care RNs	Total Requested Staff
30	20	20	120	190.

Again, FEMA has been very helpful and as of July 10, all 190 staff have been identified for this mission from the Department of Defense and from HHS, which will immensely assist the State.

Operation Airbridge

To begin, the overall approach by the Federal Government to secure, obtain, and distribute PPE to States has been an on-going challenge and should be characterized as an overall failure. In a global pandemic with world-wide competition for critical life-saving assets, a National strategy to leverage Federal buying power and consolidate asset acquisition and distribution was nonexistent. In fact, every State was on their own. It became the wild-wild west, with little or no oversight or support by the Federal Government. The amount of fraud, misrepresentation and promises broken by suppliers and would-be profiteers was simply astounding. Every State was left to compete with each other, as well as with other countries, for the same commodities.

As well, with Operation Airbridge, the States were left to compete with our own Federal Government. This approach was horrendous, resulting in massive costs and a lack of ability to secure the necessary PPE we needed for our health care workers. Although the Federal Government implemented a hybrid version of the Defense Production Act, it was not leveraged as designed and really had no positive effect on States.

Operation Airbridge was a program in which the Federal Government partnered with several U.S.-based private medical suppliers to scour manufacturers in China to obtain as much PPE as possible. The Federal Government utilized its assets to find, procure, and transport PPE. It then allocated the PPE to private medical suppliers to provide to their customers, mostly hospitals, and retained some of the PPE to build into the SNS. As we understand it, roughly half of the obtained resources went to medical supply companies and 20 percent went to the medical supply companies to sell to others, with priority for hot spots in the country. The final 30 percent was allocated to FEMA for distribution via the SNS.

As of July 3, California has received the following from the Federal Government through Operation Airbridge:

- N95 Masks.—14,757,500
- Surgical & Procedural Masks.—87,552,500
- Eye/Face Shields.—2,792,400
- Gowns & Coveralls.—34,612,300
- Gloves.—2,164,685,500.

While this effort did bring more resources into the United States, it compounded the difficulty that States were facing with securing PPE. In essence, this process “cornered the market” when the market already had limited availability. Any resources that were left or that could be obtained in the Asian market were almost entirely unavailable because of Operation Airbridge.

Lack of communication from the Federal Government caused another issue with Operation Airbridge. We did not get notification of the program until it had been active already for weeks. Our FEMA liaisons were given very little information about the operation. Once information did start to flow, the State was only told which counties were prioritized but was not given a breakdown of which facilities had received which resources. At a time when the State was developing a strategy to distribute PPE procured through its own contracts, the lack of communication caused confusion and inefficiency in resource allocation.

Operation Airbridge has been somewhat effective, but the supply chain has still not recovered. It helped fill gaps and confirm another commodity flow into the State,

but with the consequence of driving market prices up, further increasing competition, and limiting the number of resources we could secure independently.

PPE Shipments to Skilled Nursing Facilities

FEMA established a separate program specifically to distribute PPE to skilled nursing facilities. This effort, however, was not directly coordinated with the State. The State was notified of this program only after the PPE had been distributed and had little visibility over delivery dates, quantity, and locations. While this effort was well-intentioned and critically needed, there have been complaints on the quality of some products, such as gowns that fit like ponchos or masks that were not usable.

Battelle Critical Care Decontamination Systems

Through partnership with FEMA, the State-leveraged Battelle Critical Care Decontamination systems to decontaminate N95 respirators, allowing for their reuse during the supply chain shortage of this critical piece of PPE. The FDA issued an Emergency Use Authorization for the Battelle units, which can decontaminate one mask up to 20 times and can clean up to 80,000 masks per day.

On April 20, the first Battelle site was established in Burbank. The second was established in Fremont on April 25. As of July 8, California's Battelle units have decontaminated 151,356 N95 respirators for 319 facilities, with 1,864 facilities signed up for the service.

CALIFORNIA'S PPE PROCUREMENT AND DISTRIBUTION STRATEGY

Early on in the pandemic it became very clear to the State that given the volatile, competitive market fueled by scarce resources, the limited availability of PPE, an unpredictable Chinese government, and an on-going tremendous need for PPE, continuation down the same path was unsuitable. We needed a more strategic approach. We leveraged the systems and concepts we have utilized in many previous disasters to develop a multi-prong strategy to build a more manageable, reliable, and sustainable pipeline to meet the needs now, and for the duration of the event, as well as prepare for needs to re-open the economy. As we have seen across the country, some industries need to utilize PPE that have never been required to use it before, in order to mitigate any potential for COVID-19 infection. We set a path to build a sustainable, reliable capability that we could move us from a defensive position to an offensive one.

The State's PPE strategy is aligned with the Governor's 6 indicators and 4 stages of reopening. It is informed by resource requests received by relevant industry sectors' prior efforts to secure PPE, existing burn rates of PPE, and immediate needs to support operations.

Detailed further below, California's PPE strategy includes:

- Contracts;
- Contributions website and Safely Making CA;
- State PPE distribution and guidance; and
- Leveraged procurement agreements for sectors to purchase their own PPE.

State Contracts

The challenge of obtaining PPE during the world-wide supply chain shortage was worsened by fraudulent and dishonest vendors, overstated capabilities, and individuals and companies using the "seller's market" to take advantage of the global pandemic. There were cases where States were successful in getting PPE orders filled only for the shipments to be diverted, or the orders suspended, by the Federal Government. California lost shipments of swabs and face shields to this situation and saw diversions of 3 million N95 respirators. The State also lost several orders of N95 respirators due to the Chinese government shutting down PPE manufacturers and halting commodities shipments out of the country following market volatility and criticism against China.

Central to the State's PPE procurement strategy has been its contract with the California-based BYD Motors, which has significant manufacturing capabilities in China. Critical to this effort was the assistance California received from FEMA, the FDA, and the National Institute for Occupational Safety and Health (NIOSH) in moving through the certification process for the masks produced by BYD. Since receiving NIOSH certification, this contract allowed California to provide tens of millions of surgical masks and N95 respirators. California also added to its PPE pipeline by entering into agreements with numerous other State-based companies, who "re-tooled" production lines to provide assets, including:

- Bloom Energy in San Jose to repair and refurbish ventilators;
- Anheuser Bush in Los Angeles to produce hand sanitizer;
- St. Johns Knits in Los Angeles to manufacture gowns and face coverings;

- Oakley in Orange County to produce face shields;
- Virgin Orbit Rocket in Long Beach to produce ventilators;
- Ustrive Manufacturing in Los Angeles to produce cloth face masks and reusable gowns;
- Biotix in San Diego to produce face shields;
- Advoque in Santa Clara to produce N95 masks, and
- Daniels Woodland in Paso Robles to produce gowns.

Contract Vetting and Price Gouging Prevention

The State rapidly incorporated procedures and on-going checks and balances in partnership with local, State, and Federal law enforcement, including the Federal Bureau of Investigation, the U.S. Attorney's Office, and the U.S. Department of Homeland Security. The purpose of this enhanced vetting process was to help the State avoid nefarious actors and fraudulent orders.

The Governor took an additional step to combat price gouging by issuing Executive Order N-44-20 on April 3, prohibiting a company from raising the selling price of any consumer good by more than 10 percent above the regular selling price of that item on February 4, 2020. Products on which suppliers had increased the cost were excepted.

Contributions Website and Safely Making CA Portal

On March 18, the State launched a COVID-19 website to serve as a one-stop shop for information on COVID-19 State and Federal resources. A key component of this website was the Medical Supply Contributions portal, established on April 4 to facilitate the donation and distribution of PPE and other supplies from vendors and individuals.

The vetting process for this includes filtering a donation or request through a Contributions Group to determine whether the vendor has provided enough information, a Validation Group to ensure the resource will meet State specifications, and finally a Procurement Group to either pursue or disqualify the request.

To connect California businesses seeking PPE directly with California businesses selling PPE, the administration worked with the California Manufacturing Technology Association to establish the website Safely Making CA. This website fills a critical gap in helping businesses obtain non-medical grade PPE to assist in the reopening of the State. The portal also offers free licenses for cloud-based collaboration software so manufacturers can upload designs and specifications to the portal.

State PPE Distribution and Guidance

As part of California's distribution strategy, the SOC implemented a Standard Operating Procedure (SOP) for Non-Healthcare Sector and State Agency PPE Requests, which outlines the request submission protocol and the adjudication and prioritization process for PPE allocation to non-health care sectors and State agencies. Per the SOP, the SOC evaluates unmet needs through coordination with State agencies, who solicit feedback from industry stakeholders.

The PPE distribution process is also informed by the California Division of Occupational Safety and Health and the California Department of Public Health, which have been key in developing reopening and worker safety guidance documents spanning numerous industries in California.

To ensure compliance with Federal and State laws, recipients of PPE are required to maintain documentation and ensure no duplication of funds. As of July 8, California has distributed:

- N95 Masks.—80,542,775
- KN95 Masks.—2,339,450
- Surgical Masks.—201,533,482
- Cloth Masks.—9,244,100
- Face Shields.—13,941,214
- Goggles.—1,012,609
- Gowns.—14,157,598
- Coveralls.—266,340
- Gloves.—62,710,803
- Hand Sanitizer.—8,382,421
- Collection Kits.—3,937,986.

Leveraged Procurement Agreements

A major part of the State's PPE strategy is leveraged procurement agreements. Moving forward, the California Department of General Services (DGS) has issued a competitive procurement for N95 and surgical masks. The State's intent is for public entities to leverage this procurement vehicle to purchase their own PPE, rather than have the State continue to directly procure and distribute these re-

sources. The Request for Information closed on May 28, and DGS is in the process of preparing the Request for Proposal. Once it is in place in September, the State-wide procurement agreement will last for 1 year, with opportunities to extend if necessary.

MEDICAL AND TESTING SUPPLIES AND CAPACITY

California has built public-private partnerships to drastically expand our ability to collect and process specimens. Through these efforts, we are now equipped to test over 100,000 specimens per day. Despite this progress, we still have work ahead of us to ensure the supply chain is stable and that we build adequate access to testing, particularly among low-income and minority communities.

A particular problem arose with the procurement of swabs during this pandemic. The world’s production center of critically necessary swabs for COVID–19 testing is located in Italy’s hardest-hit province, which caused a global shortage of this resource. This limited supply in materials caused a slow start in California’s ability to test. We were conducting only about 2,000 tests per day in early April. This shortage required us to innovate quickly to build out a new supply chain for swabs, as well as viral transport media and specimen collection kits.

To date, California has distributed the following:

	Collection Kits	Swabs	Transport Media (vials)
Total	414,000	3.4 million	2.2 million.

As a result of these efforts, California averaged just under 106,000 tests per day from the week of July 1 to July 7. Our ultimate goal is to reach a consistent and sustainable minimum of 100,000 tests per day. As of July 9, California has conducted over 5 million tests.

Despite this progress, new spikes in cases and new supply chain issues are raising concern that our testing capacity will again be insufficient to meet the demand. A number of commercial laboratories are processing samples from testing sites across the Nation, not just from within California, and are becoming overwhelmed with the large volume. Additionally, labs within California are experiencing shortages of chemical reagents and machine cartridges, limiting processing capabilities and slowing result time lines. To address this, California has instructed all labs to prioritize samples from high-risk groups, including individuals who are COVID–19 symptomatic and those who are hospitalized or in long-term care facilities.

California is taking steps to further build out its testing capacity, even amid the current challenges. We are deploying new testing modalities, such as pooled testing, to better leverage resources. We are proactively matching organizations with laboratories to ensure we are leveraging all public and private lab capacity across the State. We have issued a survey to all local public health and academic labs to better understand supply constraints and fully utilize lab capacity for PCR testing. Finally, we are continuing to work with our Federal partners to address supply chain issues. Now more than ever, we need the Federal Government to help ensure a strong and sustainable supply chain so that we may continue and further build our testing capabilities.

Medical Surge Capacity and State Stockpile

In addition to the actions California has taken to date, we are fully aware of the possibility of concurrent medical events overwhelming our health care system. The State knows it needs to be prepared for a worst-case scenario, especially given the many unknowns of COVID–19 transmission, its interaction with influenza, and the speed at which non-pharmaceutical interventions can be instituted.

The State’s role in this situation is to support the health care system and protect vulnerable populations by augmenting existing supplies with the State stockpile. It is almost impossible to predict what the “right” amount of PPE is for fall surge planning. Variables include the number of patients hospitalized, the geographic extent of the surge, how much inventory is being produced, how much PPE institutions have in reserve, and the affordability of available PPE to the private sector. The State is using data available from Johns Hopkins University, assumptions collected by the California Health and Human Services Agency, industry association partners, and internal Cal OES data on local demand history and PPE burn rates to arrive at informed estimates for the State’s fall surge PPE stockpile. These recommendations are:

- N95 Masks.—100,000,000

- Surgical Masks.—200,000,000
- Cloth Masks.—500,000
- Face Shields.—10,000,000
- Gowns.—50,000,000
- Gloves (pairs).—200,000,000
- Coveralls.—1,500,000.

Emergency Management Assistance Compact (EMAC)

Through the Emergency Management Assistance Compact (EMAC), California has been able to provide assistance to other States. California lent ventilators to States that experienced an earlier COVID-19 spike and delivered PPE for reimbursement. California's ventilator and PPE EMAC resources include:

- *Ventilators*.—Illinois, 100; Nevada, 50; Maryland, 50; Washington DC, 50; New Jersey, 100; New York, 100; Delaware, 50; Michigan, 50. TOTAL: 1,500.
- *PPE*.—Arizona, 10,000,000 Surgical Masks, 500,000 Face Shields; Alaska, 13,000,000 Surgical Masks; Nevada, 3,000,000 Surgical Masks; Oregon, 1,000,000 Surgical Masks. TOTAL: 17,500,000.

CONCLUSION AND RECOMMENDATIONS

Thank you for the opportunity to testify before you and for your commitment to ensuring strong preparedness and response to this pandemic. To conclude, I offer the following recommendations:

- FEMA should increase the Federal share to 100 percent of the total eligible costs for emergency protective measures (Category B), including direct Federal assistance, to reduce the economic burden on State and local governments experiencing significant economic impacts, and ensure the continuity of public safety and medical/health services during this prolonged disaster. California made this request of the Federal Government on March 22, to include the first 90 days of the major disaster declaration. To date, this request has not been addressed by FEMA for California, nor for any other State that has made this same request.
- Congress should increase the appropriation to the Emergency Management Performance Grant (EMPG) by 85 percent and reform the match requirement. This pandemic has made it clear that the Federal Government must invest in building and enhancing robust emergency management capabilities on the State and local level. EMPG funding enables State, local, and Tribal governments to prepare for all hazards through planning, training, exercises, and developing professional expertise. It also supports response capabilities, emergency operation centers, public outreach campaigns, and alert and warning programs. EMPG's dollar-for-dollar match requirement has been difficult for local government to match as many have not fully rebounded from the recession. Due to the global economic crisis initiated by the pandemic, it is more important than ever that the dollar-for-dollar match be reformed to a percentage cost match consistent with the Hazard Mitigation Grant Program, currently at 25 percent.
- The SNS needs a thorough review and overhaul to build process transparency and support more realistic expectations and planning on the part of State and local government. The Federal Government must better understand the demand for life-saving SNS resources, procure and maintain those resources, and deploy them effectively.
- The Defense Production Act should be more broadly invoked for this pandemic, particularly to produce N95 respirators, to relieve the supply chain.
- The Federal Government should establish centralized commodity buying. The Federal Government would have far greater purchasing power than individual States. Leveraging this purchasing power and securing commodities for States will relieve pressure on the supply chain and competition between States in purchasing PPE and testing materials.
- As a Nation, we need to encourage more ventilator manufacturing. With the current domestic manufacturing capability and supply, the Nation is still far short of the ventilators that would be needed in the worst-case scenario.
- The Federal Government must improve its coordination. Particularly, coordination and communication must improve between HHS/ASPR, CDC, FEMA, border agencies, and regulators, to include internal communication between the headquarters and regional staff for these entities. Better coordination will allow for more streamlined communication with States and more efficient resource management and delivery, including funding.
- The Federal Government should lead unified, coordinated communications during disasters, including guidance and education for States and localities, as well

as talking points for Government officials to use when communicating with their constituents.

Ms. TORRES SMALL. Thank you for your testimony. Thank you. I now recognize Mr. Currie to summarize his statement for 5 minutes.

STATEMENT OF CHRIS P. CURRIE, DIRECTOR, HOMELAND SECURITY AND JUSTICE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. CURRIE. Thank you, Chairwoman Torres Small, Chairman Payne, Chairman Thompson, Ranking Member Crenshaw, and other Members that are here today. I appreciate the opportunity to be here to talk about GAO's work on the response to COVID-19 so far.

Just 3 weeks ago, we issued our first report on the overall Federal response to COVID-19. The report covers over \$2 trillion in Federal spending and programs, some of those programs which are brand-new and on a scale that we have never seen before.

Our folks have been working around the clock to provide oversight of this funding, and our goal, as always, is to provide accurate, fair, and balanced information to you, the Congress, and also the American people.

This pandemic and the scale of the Federal response is not even closely comparable to any disaster or public health emergency the country has faced, and we have been looking at this for over 2 decades, really since the anthrax attacks in early 2000. We have seen a marshalling of resources and a distribution of supplies that 8 months ago we would have thought was impossible. For example, for the first time in history every State in the Union, District of Columbia, most territories, and several Tribes all have Federal disaster declarations at the same time. That has never happened before.

I think it is important that we recognize the Federal, State, and local officials responding to COVID-19 around the clock and the millions of health care workers on the front lines.

Let me just be clear that there have been major challenges. However, unlike other disasters where we can only look back at the response, we are still responding to the pandemic and will be for a while. As a result, we have a unique ability in this case to make course corrections now to address rising COVID-19 cases and looming challenges this fall when flu season hits and health experts expect COVID-19 to get even worse than it is now.

I want to outline some of the challenges that we have seen in our work over the last few months, not to point fault or focus on the past, but to help figure out how we get better as we move forward.

First, it is clear that existing preparedness and response structures and resources were overwhelmed. For example, we now know that the Strategic National Stockpile was not adequate to cover Nation-wide gaps in our public health system and underinvestments in that system for several decades. It is also more clear now that prior efforts to plan and prepare for a large pandemic were both, No. 1, insufficient, and No. 2, the gaps they did identify and who was supposed to address those gaps were not fixed in time for COVID-19.

To its credit, FEMA was brought in, as you have said and others have said, mid-response in early March to lead the massive logistical effort of supply acquisition and distribution given these gaps. New command structures were established, comprised of Federal agencies to manage this effort. Historical efforts to procure and distribute supplies, such as Project Airbridge and the use of the Defense Production Act to manufacture things like respirators or ventilator components, were undertaken.

However, as we just reported a few weeks ago, it is clear that there has been confusion about, No. 1, who is exactly making resource decisions at the Federal level and how these are being prioritized for distribution to State and local governments.

Again, this is not surprising given the scale of the response, but as new supply and testing shortages arise now, we have to get more clear about roles and responsibilities moving forward between the various levels of Government.

Second, coordination and communication have to get better. We have heard from States and others that it has not been clear why Federal resources were provided when they were and how they were prioritized.

This has to work both ways, too. As States in the private sector build their stockpiles and capabilities, the Federal Government needs to know what resources they have so they can understand where the gaps are and do advance planning so those gaps can be filled when supply distributions ramp up again here soon as we get closer to the fall.

Last, the Federal Government has tremendous contracting resources and capabilities. It is one of the key strengths it brings to help States and local governments in these types of disasters or emergencies. We have reported that the use of advance contracts and coordination of these contracts help States to avoid the need for noncompetitive contracts after disasters. It also helps to avoid contract awards to companies that we later find out are unable to deliver on their promises.

FEMA also needs to ensure that they have adequate contract staff to handle this load, an issue that has been a challenge and will be a challenge as we get further into hurricane season.

Real quickly, the last issue I want to point out is on after-action reporting. Years and years of work have shown us that after-action reports sometimes are not completed, and when they are, the gaps they identify are never followed up on. It is going to be critical that every Federal agency in this response, which is almost all of them, follow up on these actions.

Thank you very much, and I look forward to your questions.

[The prepared statement of Mr. Currie follows:]

PREPARED STATEMENT OF CHRIS P. CURRIE

JULY 14, 2020

GAO HIGHLIGHTS

Highlights of GAO-20-685T, a testimony before the Subcommittee on Oversight, Management, and Accountability, and the Subcommittee on Emergency Preparedness, Response, and Recovery, Committee on Homeland Security, House of Representatives.

Why GAO Did This Study

The COVID-19 pandemic shows how biological threats have the potential to cause loss of life and sustained damage to the economy, societal stability, and global security. During the pandemic, 57 major disaster declarations were simultaneously issued for all U.S. States, the District of Columbia, and U.S. territories—the first time in history this has occurred. FEMA had obligated about \$5.8 billion for the response as of May 31, 2020.

This statement addresses: (1) FEMA’s role in managing the COVID-19 pandemic, including efforts to acquire and distribute critical medical supplies, as well as (2) potential challenges for this and other biological incident responses. This statement is based on products GAO issued from August 2003 to June 2020, as well as on-going efforts to monitor contract obligations. For these products, GAO reviewed relevant Presidential directives, statutes, regulations, policies, strategic plans, other reports, as well as Federal procurement data; and interviewed Federal and State officials, among others.

GAO provided a copy of new contract obligation information in this statement to the Department of Homeland Security for review.

What GAO Recommends

GAO made many recommendations in prior reports designed to address facets of many of the challenges discussed in this statement. Federal agencies have not fully implemented all of these but, in many cases, have taken steps. GAO will continue to monitor these efforts.

COVID 19.—FEMA’S ROLE IN THE RESPONSE AND RELATED CHALLENGES

What GAO Found

The Federal Emergency Management Agency (FEMA) administrator, together with key officials from the Department of Health and Human Services, is responsible for managing the whole-of-Nation COVID-19 pandemic response. As a primary agency responsible for managing the response, FEMA has worked in coordination with other Federal agencies to increase the availability of supplies for COVID-19—including distributing supplies to States and others through Project Airbridge in an effort to expedite distribution. FEMA’s contract obligations in response to COVID-19 totaled about \$1.6 billion as of May 31, 2020, with obligations for goods such as surgical gowns and N95 masks accounting for \$1.4 billion, or 86 percent of that total.

GAO’s recent report on the COVID-19 pandemic response and past work on other disasters has identified potential challenges FEMA faces in responding to the pandemic and any future Nationally-significant biological incidents. These challenges may be further complicated by the recent rise in COVID-19 cases and additional expected case increases in the fall.

- *Contracting.*—In December 2018, GAO found inconsistencies in how FEMA coordinated and communicated with States and localities on advance contracts—those that are established prior to disasters and are typically needed to quickly provide goods and services. GAO made recommendations to improve FEMA’s efforts and it is taking actions to address this issue.
- *Medical supply acquisition and distribution.*—In June 2020, GAO reported on concerns about the distribution, acquisition, and adequacy of supplies from the Strategic National Stockpile and other sources. GAO will continue to monitor these issues through on-going and future work.
- *Deploying disaster workforce.*—In May 2020, GAO reported on staffing shortages and other workforce challenges FEMA faced in recent disasters. The large number of declared COVID-19 disasters coupled with hurricane and wildfire seasons adds other potential challenges. GAO made recommendations designed to enhance the information FEMA officials have to manage the workforce, which FEMA agreed to implement.
- *After-action reporting.*—Analyzing lessons from the COVID-19 pandemic response may help FEMA and other agencies take corrective action for the remainder of this response and for potential future biological incidents. In May 2020, however, GAO reported that FEMA had not consistently completed prior after-action reports. FEMA agreed to implement recommendations designed to improve after-action reporting.
- *Interagency planning for biological incidents.*—In June 2020, GAO reported that the National Biodefense Strategy sets goals and objectives to help the Nation prepare for and rapidly respond to biological incidents to minimize their effect and could drive interagency preparedness efforts. However, implementation was in early stages at the start of the pandemic, and in February 2020 GAO made

recommendations designed to address key implementation challenges, including clarifying roles and responsibilities. As shown in the COVID-19 response, FEMA's role in these efforts will be critical. GAO will continue to monitor preparedness and strategy implementation.

Chairwoman Torres Small, Chairman Payne, Ranking Member Crenshaw, Ranking Member King, and Members of the subcommittees: I am pleased to be here today to discuss our work on the Federal Emergency Management Agency's (FEMA) roles and responsibilities during the response to the Coronavirus Disease 2019 (COVID-19) pandemic.¹ While the COVID-19 pandemic continues to unfold and present new challenges, it also demonstrates how biological threats have the potential to cause catastrophic loss of life and sustained damage to the economy, societal stability, and global security. We recently issued our first comprehensive look at the overall Government response to the COVID-19 pandemic, in which we reported on the multiple Federal efforts to help address the health effects and the spillover effects of the pandemic on the economy.² As of July 6, 2020, there were over 2.8 million reported COVID-19 cases and over 129,000 reported deaths in the United States, according to the Centers for Disease Control and Prevention (CDC). In addition, from March 21 to May 30, 2020, there was an increase of over 42 million unemployed Americans and an overall downturn in the U.S. economy. The operational response to the pandemic has required support from all of the Nation's existing systems and structures designed to help manage the response to both public health emergencies and natural disasters across multiple Federal departments.

To help the Nation prepare for disasters regardless of origin, the Department of Homeland Security (DHS) issued *The National Response Framework*, which describes how the Federal Government, States and localities, and other public and private-sector institutions should respond to disasters.³ For example, State, local, Tribal, and territorial governments are to play the lead roles in disaster response and recovery. Federal agencies can become involved in responding to a disaster, such as when the President declares a major disaster in response to a request by the Governor of a State or territory or by the chief executive of a Tribal government, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).⁴ Such a request is based on a finding that the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary. A Stafford Act declaration is a key mechanism by which the Federal Government becomes involved in funding and coordinating response and recovery activities. For example, FEMA uses mission assignments and the Public Assistance and Individual Assistance programs to support response efforts and obligated \$5.8 billion for COVID-19 as of May 31, 2020.⁵ During the COVID-19 pandemic, 57 major disaster declarations have been issued simultaneously for all U.S. States, the District of Columbia, and U.S. territories—the first time in history this has occurred.⁶

In May 2020, we reported that the 2017 and 2018 hurricanes, wildfires, and other recent disasters highlight the challenges that all levels of government face in preparing for and responding effectively to disasters—in terms of both immediate re-

¹ COVID-19 is a strain of coronavirus to which the public does not have immunity. It was first reported on December 31, 2019, in Wuhan, China. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency for the United States, retroactive to January 27. On March 13, 2020, the President declared COVID-19 a National emergency under the National Emergencies Act.

² GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, DC: June 25, 2020).

³ Presidential Policy Directive-8 National Preparedness (PPD-8) establishes a National preparedness system made of an integrated set of guidance, programs, and processes designed to strengthen the security and resilience of the United States through systematic preparation for the natural and human-caused threats that pose the greatest risk. This system breaks preparedness activities into 5 different lines of effort—prevention, protection, mitigation, response, and recovery—each of which requires a separate planning framework.

⁴ 42 U.S.C. § 5170.

⁵ Mission Assignments are work orders FEMA issues that direct another Federal agency to utilize its authorities and the resources granted to it under Federal law to provide direct assistance to State, local, Tribal, and territorial governments. The Public Assistance program provides assistance to State, Tribal, territorial, and local governments. For example, for the COVID-related declarations, States can use FEMA's Public Assistance program grant funding for actions that lessen the immediate threat to public health and safety, like standing up emergency medical facilities. In addition, FEMA's Individual Assistance program, which provides assistance to help individuals and households recover following a disaster, can also reinforce State and local services provided to help individuals cope with the pandemic, such as for crisis counseling.

⁶ Major disaster declarations include all 50 States, the District of Columbia, 5 territories, and the Seminole Tribe of Florida. In addition, 32 Tribal entities are working directly with FEMA under the March 13, 2020, Nation-wide emergency declaration.

sponse and long-term recovery efforts. Our prior work has identified FEMA’s challenges in preparing for, responding to, and recovering from major disasters and also highlighted the need to ensure transparency for tracking Federal contracting obligations for major disasters through proper accounting mechanisms.⁷ In its *2017 Hurricane Season After-Action Report*, FEMA acknowledged that the agency must better prepare for sequential, complex disasters and address logistical challenges that may complicate efforts to deploy resources to remote areas.⁸ As the Nation continues to battle the on-going pandemic, a recent spike in case numbers, and additional expected increases in the fall, it also must maintain nimbleness to address other likely concurrent disasters, such as hurricanes and wildfires, that will rely on some of the same response capabilities currently being used to address the pandemic, including FEMA’s workforce.

My testimony today highlights key findings from our recent prior work on: (1) FEMA’s role in managing the response to the COVID–19 pandemic, including efforts to acquire and distribute critical medical supplies, and (2) what our prior work suggests about potential challenges going forward for this and any other responses to Nationally significant biological incidents.⁹ The statement is based on our prior work issued from August 2003 through June 2020 on various preparedness and response issues, including those for biological threats, as well as our on-going efforts to monitor contract obligations.

To conduct our prior work, we reviewed relevant Presidential directives, statutes, regulations, policies, strategic plans, and other reports; and interviewed Federal and State officials, among others. More information on our scope and methodology can be found in each of the reports cited throughout this statement. As part of our work on FEMA’s contract obligations and use of Defense Production Act authorities in response to COVID–19, we reviewed DHS and FEMA guidance and information, and Federal Procurement Data System—Next Generation data through May 31, 2020.¹⁰ We identified contract actions and associated obligations related to COVID–19 using the National Interest Action code, as well as the contract description. We assessed the reliability of Federal procurement data by reviewing existing information about the Federal Procurement Data System—Next Generation and the data it collects—specifically, the data dictionary and data validation rules—and performing electronic testing. We determined that the data were sufficiently reliable for the purposes of describing FEMA’s reported contract obligations in response to COVID–19.

The work upon which this statement is based was conducted in accordance with generally accepted Government auditing standards. 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.

FEMA’S ROLE IN MANAGING THE COVID–19 RESPONSE

Leadership of the whole-of-Nation response.—As part of the interagency group with responsibility for leading the whole-of-Nation response and the Federal official responsible for the operations of the National Response Coordination Center (NRCC),¹¹ the FEMA administrator has a key role in managing the COVID–19 response. This includes responding to States’ needs for critical medical supplies.¹² According to the FEMA administrator’s June 2020 testimony before the Senate Committee on Homeland Security and Government Affairs, on March 19, under the di-

⁷ GAO, *National Preparedness: Additional Actions Needed to Address Gaps in the Nation’s Emergency Management Capabilities*, GAO–20–297 (Washington, DC: May 4, 2020); and GAO, *2017 Disaster Contracting: Actions Needed to Improve the Use of Post-Disaster Contracts to Support Response and Recovery*, GAO–19–281 (Washington, DC: Apr. 24, 2019).

⁸ Federal Emergency Management Agency, *2017 Hurricane Season After-Action Report* (Washington, DC: July 12, 2018).

⁹ According to the 2018 National Biodefense Strategy, a “biological incident” is: (1) Any act of biological warfare or terrorism; (2) a crime involving a biological agent or biologically active substance; or (3) any natural or accidental occurrence in which a biological agent or biologically active substance harms humans, animals, plants, or the environment. By “Nationally significant,” we mean biological incidents that have the potential for catastrophic consequences, such as the potential to affect a large portion of the United States or the potential for catastrophic economic consequences.

¹⁰ For the purposes of this statement, “contract obligations” means obligations on contracts that are subject to the Federal Acquisition Regulation, and does not include, for example, grants, cooperative agreements, loans, other transactions for research, real property leases, or requisitions from Federal stock.

¹¹ The NRCC is a multiagency coordination center located within FEMA headquarters.

¹² GAO–20–625.

rection 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 response, to directing it.

As with any emergency or major disaster requiring a coordinated Federal response, the NRCC serves as the interagency coordination hub for response actions and resources for the COVID-19 pandemic response. According to FEMA officials, to help lead the response, the administrator activated the NRCC to the highest level—which includes full staffing of all key interagency functions—on March 19. The NRCC can bring to bear the existing authorities, processes, resources, and funding that the various Federal agencies can offer to meet response needs.

The Unified Coordination Group—made up of the FEMA administrator, the HHS assistant secretary for preparedness and response, and a CDC representative—has responsibility for operational command, leadership, and decision making for the COVID-19 pandemic response. The 3 leaders are partners in operational decision making for the response and provide input to the White House Coronavirus Task Force. According to FEMA and HHS officials involved in the response and operational documents used in response coordination, FEMA, the Assistant Secretary, and CDC have complementary roles that correspond to their missions and expertise. The FEMA administrator, for example, focuses on directing Nation-wide operational needs—such as the logistics of moving material, supplies, and personnel to meet emergent needs and tracking the delivery of these supplies. We are conducting ongoing work reviewing FEMA's actions in response to the pandemic under the Stafford Act, including any challenges FEMA faces in coordinating and providing resources to States and Tribal entities.

Efforts to acquire and distribute critical medical supplies.—FEMA has relied on various mechanisms to procure needed goods and services. As part of the Federal response to the pandemic, FEMA has worked in coordination with HHS and the Department of Defense (DOD) to increase the availability of supplies for COVID-19—including purchasing and distributing supplies to States and others. As part of the response led out of the NRCC, task forces, representing different functional lines of effort, provide operational guidance and secure resources to coordinate the whole-of-Government response. We reported in June 2020, that, according to FEMA officials, these task forces bring together Federal departments and agencies with the relevant expertise, authorities, and capabilities necessary to address unmet needs.¹³ One of these is the Supply Chain Task Force, which is led jointly by detailees from DOD and FEMA and has the objective of maximizing the Nation-wide availability of mission-essential protective and life-saving resources and equipment based on need.

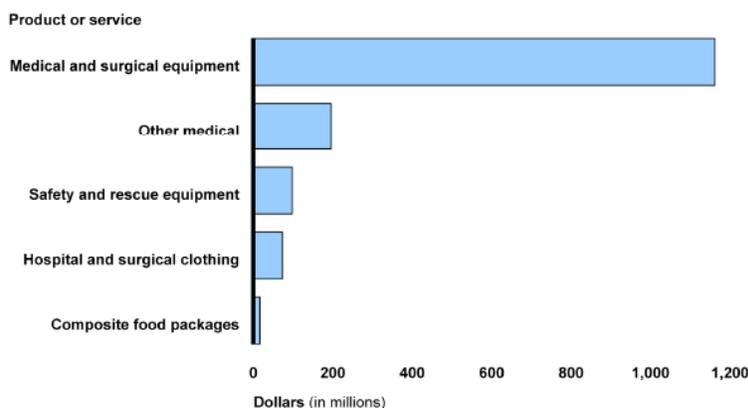
According to FEMA officials, the Supply Chain Joint Task Force's efforts have largely been led by FEMA's Office of the Chief Procurement Officer to address limited supplies of personal protective equipment, ventilators, and other needed resources.¹⁴ FEMA has used various contracting mechanisms to support its efforts.

Based on preliminary observations from our on-going review of Government-wide contract obligations, FEMA's contract obligations in response to COVID-19 totaled about \$1.6 billion as of May 31, 2020, with obligations for goods accounting for \$1.4 billion, or 86 percent of that total. Our preliminary analysis of contract obligations reported in the Federal Procurement Data System—Next Generation indicates that over three-quarters of FEMA's obligations on goods were reported as medical and surgical equipment, such as reusable surgical gowns and N95 respirators or masks for medical professionals. See figure 1 for the top categories of goods and services FEMA procured.

¹³ GAO-20-625.

¹⁴ In May 2020, FEMA officials told us that HHS, FEMA, and the Supply Chain Task Force would be transitioning some of the procurement responsibilities previously led by FEMA to DOD.

Figure 1: Top Products and Services Procured through the Federal Emergency Management Agency’s Federal Contracts in Response to COVID-19, as of May 31, 2020



Our preliminary analysis also found that about \$1.4 billion of FEMA’s contract obligations were awarded on new contracts, compared to preexisting contracts established before the pandemic.¹⁵ We plan to issue future products focused on agencies’ planning and management of contracts awarded in response to the pandemic, including a report later this month that will describe, among other things, key characteristics of Federal contracting obligations awarded in response to COVID-19.

In addition to contracting for goods and services, we further reported in June 2020 that, as part of the Supply Chain Task Force, FEMA has also been involved in the delivery of personal protective equipment and supplies through Project Airbridge.¹⁶ This effort—developed in coordination with 6 large medical supply distributors—was intended to reduce the time it takes to receive needed supplies from overseas manufacturers. According to FEMA, the agency pays for the air transportation of supplies from overseas to the United States, 50 percent of which are distributed to areas of need based on CDC data. The medical suppliers distribute the remaining 50 percent through their normal commercial networks, although, according to FEMA officials, the Federal Government has purchased some of these supplies to provide to the States. In mid-June, FEMA reported that the Unified Coordination Group is phasing out Project Airbridge, now that the supply chain for personal protective equipment has stabilized across the United States.

Use of Defense Production Act authorities.—Based on preliminary observations of our on-going work on the use of the Defense Production Act, FEMA has used Defense Production Act Title I authority to place priority ratings on orders of personal protective equipment in response to COVID-19.¹⁷ Specifically, FEMA officials told us they placed priority ratings on 3 orders from 3M and received about 49 million N95 respirators from April 12, 2020, through May 20, 2020. According to DHS Ac-

¹⁵ New contract obligations include obligations on new definitive contracts (as reported in the Federal Procurement Data System-Next Generation), purchase orders, indefinite delivery vehicles, and blanket purchase agreements awarded after February 4, 2020—the date of the first contract obligations in response to COVID-19—and all associated orders, calls, and modifications to these awards. Preexisting contract obligations include obligations on orders, calls, and modifications to definitive contracts, purchase orders, indefinite delivery vehicles, and blanket purchase agreements awarded prior to February 4, 2020. A definitive contract means any contract that must be reported in the Federal Procurement Data System—Next Generation other than an indefinite delivery vehicle. This definition is only relevant for Federal Procurement Data System—Next Generation reporting.

¹⁶ GAO-20-625.

¹⁷ According to DHS guidance on the Federal Priorities and Allocations System, a contract or order containing a priority rating requires the contractor (and the contractor’s supply chain) to provide preferential treatment to fulfil the delivery requirements of the rated contract or order. Department of Homeland Security, Office of the Chief Procurement Officer, *Federal Priorities and Allocations System: A Guide for Placing Priority Ratings on Contracts and Orders* (Washington, DC: March 2020).

quisition Alert Notice 20–13, DHS components must seek authorization by the Unified Coordination Group and the White House Task Force before placing a priority rating on a contract for COVID–19. Our on-going work will further examine FEMA’s role in procuring and distributing critical goods and how Federal agencies used authority under the Defense Production Act to obtain needed supplies.

POTENTIAL CHALLENGES IN THIS AND FUTURE RESPONSES

Our prior work and the nature of this response suggest issues that may present challenges for FEMA as this response continues and for any future incidents. Monitoring known challenges and incorporating lessons learned from the early phases of the COVID–19 response will provide critical information to inform improvement efforts for the on-going response. Moreover, as the Federal Government continues to take necessary steps to protect the American public during the on-going pandemic, we must not lose sight of the next potential threat. Our work had identified challenges, and in many cases made recommendations, that may be relevant for FEMA. Among these are challenges related to: (1) Contracting, (2) medical supply acquisition and distribution during the pandemic, (3) deploying the disaster workforce, (4) after-action reporting, (5) interagency planning for Nationally significant biological incidents, and (6) building and assessing non-Federal capabilities for such incidents.

Contracting.—Our prior work has identified coordination challenges between FEMA, other Federal agencies, and States and localities related to the use of contracts following the 2017 disasters. In April 2019, we found that FEMA’s guidance lacked details on how FEMA and other Federal agencies should coordinate contracting considerations as part of mission assignments.¹⁸ We recommended that FEMA revise its mission assignment policy and guidance to better incorporate consideration of contracting needs and to ensure clear communication of coordination responsibilities related to contracting. FEMA concurred with the recommendation and stated it would work with other Federal agencies to develop mission assignment tools, training, and guidance to address these issues.

We have also identified challenges with FEMA’s coordination and communication with States and localities over the use of advance contracts. In December 2018, we found inconsistencies in how FEMA was coordinating with States and localities and the information FEMA used to communicate with States and localities on advance contracts.¹⁹ We recommended that FEMA provide specific guidance to its contracting officers to perform outreach to States and localities to encourage and guide them on the use and establishment of advance contracts, and communicate information on available advance contracts. FEMA concurred with our recommendations and has taken some steps to update its guidance and improve communication. Effective coordination between FEMA and its Federal, State, and local partners helps ensure that stakeholders have the tools needed to facilitate their emergency response efforts.

Moreover, our prior work has noted that agencies, including FEMA, can leverage contracts awarded in advance of a disaster to rapidly and cost-effectively mobilize resources and that these contracts can help preclude the need to procure critical goods and services noncompetitively.²⁰ In December 2018, we recommended that FEMA update its advance contract strategy to clearly define the objectives of advance contracts, how they contribute to FEMA’s disaster response operations, and how they should be prioritized in relation to new, post-disaster contract awards. FEMA concurred with this recommendation and has taken some steps to provide additional guidance on the use of advance contracts, but its actions are still in progress. Our future work will examine contracting lessons learned related to planning for future public health emergencies.

Medical supply acquisition and distribution during the pandemic.—In June 2020, we reported on concerns about the distribution, acquisition, and adequacy of supplies from the Strategic National Stockpile and other sources.²¹ For example, in April 2020, the National Governors Association—whose membership comprises State governors, territories, and commonwealths—noted in a memorandum to Governors’ offices that Governors individually and through the association had called

¹⁸ GAO–19–281.

¹⁹ GAO, *2017 Disaster Contracting: Action Needed to Better Ensure More Effective Use and Management of Advance Contracts*, GAO–19–93 (Washington, DC: Dec. 6, 2018).

²⁰ GAO–19–93.

²¹ GAO–20–625. The Strategic National Stockpile, which is overseen by the HHS Assistant Secretary for Preparedness and Response, is the largest Federal repository of critical medical supplies. When FEMA was designated as the lead Federal agency for the pandemic response, responsibility for allocation, distribution, and procurement of supplies shifted from HHS to the Supply Chain Task Force.

for improved coordination in the Federal response to enable States to obtain critical supplies.²²

The National Governors Association further noted that a more coordinated Federal role would help States to obtain personal protective equipment, ventilators, and other critical supplies to protect responders and save lives without competition between States and with the Federal Government. Similarly, the Governors of Colorado and Michigan testified before the House Committee on Energy and Commerce in June 2020 that coordination of supplies between the Federal Government and States needed to be improved. We previously raised concerns about supply gaps. Specifically, in 2003, we reported that urban hospitals lacked the necessary equipment, such as personal protective equipment, to respond to a large influx of patients experiencing respiratory problems caused by a bioterrorism event.²³ Such an event would require a similar response to the naturally-occurring COVID-19 outbreak.

Officials from the HHS Assistant Secretary for Preparedness and Response's office and FEMA officials told us that they did not consider the views of the National Governors Association to be representative or reflective of the entire response effort. Moreover, HHS officials noted that many State stockpiles were inadequate and that public reporting provides examples where Governors and mayors made unnecessarily large demands for Federal resources. FEMA officials also noted that States overestimated their needs for supplies, such as ventilators. Although we requested information on the Strategic National Stockpile inventory prior to the pandemic—such as the types and amounts of supplies that States requested, as well as what the assistant secretary and FEMA distributed from the stockpile in response to States' requests—HHS and FEMA had not yet provided this information as of June 12, 2020. We plan to continue to seek this information from the agencies.

In addition to the statements made by the National Governors Association, in June 2020, a National Emergency Management Association official testified before the Senate Committee on Homeland Security and Government Affairs about the challenges States faced accessing the Strategic National Stockpile. These challenges included limited visibility into the availability of supplies and a failure to receive items needed in a sufficient quantity or useable condition. For example, some States reported receiving supplies that were past a functional expiration date. In addition, this official noted that States reported problems with receiving supplies from other sources intended to fill the gap in the stockpile, such as long delivery times (e.g., 46 days for a shipment of surgical gowns for one State), shipments sent to the wrong locations, and supplies ordered that never arrived.

We are conducting a comprehensive body of work on the Strategic National Stockpile in response to the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 and the CARES Act.²⁴ As part of this work, we plan to review progress made in restructuring the stockpile based on lessons learned from recent pandemics, an effort the administration announced on May 14, 2020. Further, we also plan to examine the alignment of supplies in the stockpile with threat risks; coordination and communication with States, territories, localities, and Tribes; and actions taken, if any, to mitigate supply gaps. We are also examining the role that FEMA played in distributing supplies in conjunction with HHS and others and how Federal agencies used authority under the Defense Production Act to obtain needed supplies.

Deploying disaster workforce.—FEMA may face challenges in its ability to deploy its workforce in response to other disasters in addition to COVID-19. In May 2020, we reported that FEMA faced staffing shortages during the 2017 and 2018 disaster seasons, 2 years that were particularly challenging due to the number and severity of disasters experienced.²⁵ We further reported that FEMA's qualification and deployment processes did not provide reliable and complete staffing information to field officials to ensure effective use of the deployed workforce. We made recommendations on this issue, among others, which FEMA agreed to implement.

Our prior work has also found that FEMA's ability to plan and manage contracts during a disaster is also complicated by persistent acquisition workforce challenges, including attrition and staffing shortages. In April 2019, we found that FEMA had

²² National Governors Association, *Governor Actions to Address PPE and Ventilator Shortages* (Washington, DC: Apr. 13, 2020), available at <https://www.nga.org/wp-content/uploads/2020/04/NGA-Medical-Equipment-Memo.pdf>.

²³ GAO, *Hospital Preparedness: Most Urban Hospitals Have Emergency Plans but Lack Certain Capacities for Bioterrorism Response*, GAO-03-924 (Washington, DC: Aug. 6, 2003).

²⁴ Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019, Pub. L. No. 116-22, § 403(a)(5), 133 Stat. 905, 946-47; CARES Act, Pub. L. No. 116-136, § 19010, 134 Stat. 281, 579-81 (2020).

²⁵ GAO, *FEMA Disaster Workforce: Actions Needed to Address Deployment and Staff Development Challenges*, GAO-20-360 (Washington, DC: May 4, 2020).

identified workforce shortages as a challenge but had not assessed its contracting workforce needs since at least 2014.²⁶ We recommended that FEMA assess its workforce needs to address these shortcomings and develop a plan, including time lines. FEMA concurred with the recommendation and has taken some steps to address it.

The large number of declared disasters for the COVID-19 pandemic and the lack of disaster management experience in this area add additional layers of complexity to FEMA's response. Therefore, it is critical that FEMA give leaders and managers in the field information to help them respond flexibly and effectively. While continuing to respond to the pandemic, FEMA and the Federal Government must also be prepared to respond when the next disaster inevitably strikes. We will continue to monitor Federal efforts to respond to the pandemic—including FEMA's role in coordinating response and recovery efforts Nation-wide and Federal efforts to prepare for large-scale biological events—as well as challenges FEMA and other Federal agencies face in ensuring that they are able to respond to major disasters and emergencies effectively and equitably.

FEMA after-action reporting.—FEMA policy requires that after-action reviews be conducted after Presidentially-declared major disasters to identify strengths, areas for improvement, and potential best practices of response and recovery efforts. However, we reported in May 2020 that, as of January 2020, FEMA had completed after-action reviews for only 29 percent of disasters since January 2017.²⁷ Further, we reported that FEMA lacks a formal mechanism for documenting and sharing best practices, lessons learned, and corrective actions Nation-wide.

Information collected and reported following a pandemic can inform responses to future public health emergencies. Furthermore, the National Response Framework specifies that evaluation and continual process improvement are cornerstones of effective preparedness. Ensuring that FEMA and all other agencies participating in the COVID-19 response are consistently identifying best practices and areas of improvement will be critical to mounting an effective response now and in the future. In May 2020, we recommended that FEMA prioritize the completion of after-action reviews, document lessons learned at the headquarters level, and develop guidance for sharing such reviews with external stakeholders, when appropriate. DHS concurred with our recommendations and stated that it is taking steps to address them, including by implementing a new system for tracking best practices and lessons learned, among other things.

Interagency planning for Nationally significant biological events.—Since 2011, we have called for a more strategic approach to guiding the systematic identification of risks, assessing resources needed to address those risks, and prioritizing and allocating investments across the biodefense enterprise.²⁸ In September 2018, the White House issued the National Biodefense Strategy (Strategy) and characterized it as a new direction to protect the Nation against biological threats. At the same time, the President issued the Presidential Memorandum on the Support for National Biodefense/National Security Presidential Memorandum-14 (NSPM-14), which details a governance structure and implementation process to achieve the Strategy's goals. For example, it established 2 governing bodies: The Biodefense Steering Committee—chaired by the Secretary of HHS—and the Biodefense Coordination Team, to support the efforts of the Steering Committee. In our February 2020 report, we found that the Strategy and associated plans bring together all the key elements of Federal biodefense capabilities, which presents an opportunity to identify gaps and consider enterprise-wide risk and resources for investment trade-off decisions.²⁹

In February 2020, we reported that the Strategy and its associated plans bring together the efforts of Federal agencies with significant biodefense roles, responsibilities, and resources to address intentional, accidental, and naturally-occurring threats and is an important step toward the kind of enterprise-wide strategic decision making we have called for. In June 2020, we also reported that the Strategy sets goals and objectives to help the Nation prepare for and rapidly respond to biological incidents to minimize their effect. As such, implementing the strategy could

²⁶ GAO-19-281.

²⁷ GAO-20-297.

²⁸ GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO-11-318SP (Washington, DC: Mar. 1, 2011). The biodefense enterprise is the whole combination of systems at every level of Government and the private sector that contribute to protecting the Nation and its citizens from potentially catastrophic effects of a biological event. It is composed of a complex collection of Federal, State, local, Tribal, territorial, and private resources, programs, and initiatives designed for different purposes and dedicated to mitigating both natural and intentional risks.

²⁹ GAO, *National Biodefense Strategy: Additional Efforts Would Enhance Likelihood of Effective Implementation*, GAO-20-273 (Washington, DC: Feb. 19, 2020).

help the Federal Government prepare for Nationally significant events like the COVID-19 pandemic.

However, as we reported in February 2020, the Strategy efforts under way represented a start to a process and a cultural shift that may take years to fully develop. Given the timing of the COVID-19 pandemic, the Strategy had not had time to drive change in response planning and other biodefense functions, and we identified multiple challenges that could affect the Strategy's implementation, including challenges in adapting to new procedures, a lack of clarity in roles and responsibilities for joint decision making, and a lack of defined resources to sustain on-going efforts. We made recommendations to the Secretary of Health and Human Services, as the agency responsible for coordinating interagency strategy efforts to address these implementation challenges. HHS agreed to implement these recommendations. Given the experience of the COVID-19 response, FEMA's role and contribution to on-going interagency planning efforts for Nationally significant biological incidents will be critical. We have on-going work on preparedness for and response to COVID-19 and other such Nationally significant events and expect to report in early 2021.

Building and assessing capabilities.—In our February 2020 review of the National Biodefense Strategy, we reported that the initial Federal effort to collect information on all biodefense-related programs, projects, and activities focused on existing Federal activities and did not include a complete assessment of biodefense capabilities at the non-Federal level—capabilities needed to achieve the goals and objectives outlined in the Strategy. We recommended that HHS take steps to ensure that non-Federal resources and capabilities are accounted for in the analysis of the Nation's biodefense efforts. HHS agreed and described steps it is taking to address this recommendation.

Capabilities at the non-Federal level are critical for supporting key functions in biological incident response, and building them has been an on-going challenge, as our prior work demonstrates. According to Federal, State, and local officials, early detection of potentially serious disease indications nearly always occurs first at the local level, making the capabilities of personnel, training, systems, and equipment that support detection at the State and local level a cornerstone of our Nation's biodefense posture.³⁰ In June 2019, we testified that establishing and sustaining biosurveillance capabilities can be difficult for a myriad of reasons.³¹ For example, maintaining expertise in a rapidly changing field is difficult, as is the challenge of accurately recognizing the signs and symptoms of rare or emerging diseases.³² Additionally, we reported in October 2011 that funding targeted for specific diseases does not allow for a focus on a broad range of causes of morbidity and mortality, and Federal officials have said that the disease-specific nature of funding is a challenge to States' ability to invest in core biosurveillance capabilities.³³ As we testified in June 2019, implementation of the National Biodefense Strategy offers the opportunity to design new approaches to identifying and building a core set of capabilities for emerging infectious diseases. However, implementation efforts are on-going and it is yet to be determined how, if at all, implementation efforts will address this long-standing challenge.

In our prior work in March 2011, we also recommended that FEMA complete a National preparedness assessment of capability gaps at each level of Government based on tiered, capability-specific performance objectives to enable prioritization of grant funding.³⁴ However, as of March 2020, this recommendation has not been implemented.

In summary, the response to the COVID-19 pandemic has relied on both public health and emergency management capabilities, which are often governed by different authorities and directed by different agencies at the Federal and non-Federal level. As the Government looks to the future and takes steps to plan, prepare, and respond to future biological incidents of National concern, addressing the rec-

³⁰ GAO, *Biosurveillance: Non-Federal Capabilities Should Be Considered in Creating a National Biosurveillance Strategy*, GAO-12-55 (Washington, DC: Oct. 31, 2011).

³¹ GAO, *Biodefense: The Nation Faces Long-standing Challenges Related to Defending Against Biological Threats*, GAO-19-635T (Washington, DC: June 26, 2019). Biosurveillance, as defined by the July 2012 National Strategy for Biosurveillance, is the on-going process of gathering, integrating, interpreting, and communicating essential information related to all-hazards threats or disease activity affecting human, animal, or plant health, for the purpose of: (1) Achieving early detection and warning, (2) contributing to overall situational awareness of the health aspects of the incident, and (3) enabling better decision making at all levels.

³² GAO, *Biosurveillance: Efforts to Develop a National Biosurveillance Capability Need a National Strategy and a Designated Leader*, GAO-10-645 (Washington, DC: June 30, 2010).

³³ GAO-12-55.

³⁴ GAO-11-318SP.

ommendations we have made to better address capability gaps can help better position the Nation for what comes next. We are planning upcoming work on Federal efforts at DHS and HHS to support building non-Federal capabilities to respond to and recover from Nationally significant biological incidents.

Chairwoman Torres Small, Chairman Payne, Ranking Member Crenshaw, Ranking Member King, and Members of the subcommittees, this concludes my prepared statement. I would be happy to respond to any questions you may have at this time.

Ms. TORRES SMALL. Thank you for your testimony, Mr. Currie. I deeply appreciate it.

I thank all of the witnesses for their testimony, and I will remind each Member that he or she will have 5 minutes to question the panel. Without objection, Ms. Jackson Lee will be permitted to sit and question the witnesses as well.

I now recognize myself for questions.

We have heard, especially toward the start of this pandemic, the market for PPE and other medical equipment was difficult to navigate, to say the least, due to competition from other States and little guidance from the Federal Government.

Mr. Fugate, as the lead Federal agency, what do you think FEMA's role should have been in providing a National procurement strategy to avoid unnecessary competition and bidding wars between States?

Mr. FUGATE. Well, for FEMA this is brand-new. They don't procure this type of equipment on these scales. So the learning curve is very painful. I think probably the biggest problem I saw early on is nobody was thinking a big number.

If you are going to use the Defense Production Act, you have to use it early. The problem is, there was not certainty it was going to get that bad. We can go back to H1N1 in 2009 where we prepared for a much worse pandemic, but the United States was basically spared some of the impacts other country did.

So we didn't have a big number, we didn't turn on things early because the indicators, by the time it indicated a need, were already behind the power curve, and then it was a mad scramble. Everybody was trying to get PPE and it became a competition.

I think we have to codify these rules ahead of time.

Ms. TORRES SMALL. Thank you, Mr. Fugate.

Mr. Currie, do you have anything to add in terms of FEMA's role in providing a National strategy?

Mr. CURRIE. Well, I agree with Mr. Fugate. I don't think anybody at the Federal level expected the pandemic to be this bad, and, as you said, this is why FEMA was called in late in the game, because they were the only ones left that actually had resources anywhere close to be able to handle something like this.

I have to go back to preparedness. We have found over and over, again, for example, in 2019, Crimson Contagion, the exercise was conducted that was very similar to a pandemic situation like this, one of the key vulnerabilities it identified was that supply distribution and prioritization was going to be a mess.

So we didn't take the steps and didn't devote the resources to address it then. It is very difficult to address these things before something like this actually happens. But we do have the information to do it.

I think now, as I said in my opening, this response is still ongoing, so all is not lost. We are not just looking back. We can address these issues now for the future.

Ms. TORRES SMALL. Thank you, Mr. Currie.

Mr. Ghilarducci, California has an incredibly diverse population in several rural communities, which is similar to my State of New Mexico.

Can you talk about whether there are any inequalities in the availability of supplies within the State and how you ensure that rural areas are adequately equipped to combat COVID-19?

Mr. GHILARDUCCI. Yes. Great question.

So one of the major efforts that we put forth and lean deep into is to ensure that our rural communities in areas where maybe communities that had a lack of direct access to these kind of commodities were sourced and supplied efficiently and effectively, particularly smaller hospitals.

We would wrap around those smaller health care systems with not only PPE, but personnel, to ensure that they had the capability they need to sustain themselves.

But look, it is a big State and part of the effort was to initially decompress hospitals. So part of that was building in these Federal and field medical stations and other kinds of field alternative care sites to be able to help those communities.

In rural California and in far north California, where we have very diverse populations, those were primary areas to ensure that we had enough resources.

Ms. TORRES SMALL. Thank you, Mr. Ghilarducci.

To follow up on that, part of the diversity is Indian Tribes, and right now FEMA assistance for COVID-19 requires a 25 percent match from States and Indian Tribes at a time when the virus is also drying up State and Tribal revenues and leading to budget shortfalls.

So in the limited remaining time, can you speak on the disproportionate impact the virus is having, and start with whether you believe waiving the cost-share would enhance Tribes' ability to respond to the pandemic?

Mr. GHILARDUCCI. Well, certainly Tribes are unique in that they have the opportunity to either acquire assistance from the Federal Government directly or in some cases come to the State for assistance.

But let me be clear, waiving the cost share in this particular endeavor, this is such a massive, complicated event that is long, really a marathon, the fiscal impact across the board, as we have seen in the State, across other States in the country, is massive.

So if any event would be required to waive the cost-share really it would be this one and it certainly could be very beneficial to Tribes and local governments and State governments as well.

Ms. TORRES SMALL. Thank you, Mr. Ghilarducci.

I yield the remainder of my time.

So I now recognize the Ranking Member of the Subcommittee on Oversight, Management, and Accountability, the gentleman from Texas, Mr. Crenshaw, for questions.

Mr. CRENSHAW. Thank you, Madam Chairwoman.

Again, thank you, everyone, for being here.

This question is for Mr. Fugate. I just want to get a sense of—we can always nitpick and Monday morning quarterback in hindsight, but that is useful only to an extent. We have to understand what is truly possible to change in a realistic way.

So along those lines, when it became clear that certain items were needed as part of the response, Operation Airbridge brought in and distributed PPE and other needed supplies. The Defense Production Act was invoked to ramp up ventilator production. On February 24, the President asked Congress for money to fight COVID. It was, unfortunately, delayed at least a week after requested.

Congress passed 3 COVID-related bills in March that were signed into law, and the Federal Government, through the Coronavirus Task Force, has continued to provide support.

What additional action should the Federal Government have taken? I mean, when was there a fork in the road where we went left and we should have gone right? That would be a critical way to assess what we could have done better and maybe learn lessons for the future.

Mr. FUGATE. Well, my observations—and, again, this is my opinion—we never looked at worst-case, big-number scenarios.

My experience has been we always try to make the disaster fit our capabilities instead of looking at how bad something is going to be and what would be the potential shortfalls and how would we address it.

As you find with pandemics, if you are waiting for certainty, you are too late. So it was we weren't looking at big enough numbers to see what the delta was between what we were doing and what the potential demand was.

Quite honestly, I would much rather testify to you that I got too much stuff than I ran out. I think that is the thing we have to really enforce here, is that we cannot right-size these types of responses. We have to have too much or we are always going to run out.

Mr. CRENSHAW. Are you referring to—it seems like, as Mr. Currie had stated before, you are not referring to a decision made in the last few months; you are referring to decisions made over the last few years of preparation.

Mr. FUGATE. Absolutely.

Mr. CRENSHAW. OK.

Mr. FUGATE. We looked at our stockpile as a push package. It was never designed to respond to a pandemic. It was only designed to be the first things out the door. But we have to also understand what the demand signal was, and with a novel virus, there was no telling.

So essentially you can start taking what I call [inaudible]. How many people in the health care industry are we going to have to provide PPE for in every State simultaneously? That is a big number. What is our delta between what we can do now and what we can do to meet that number?

Mr. CRENSHAW. Do you have any insight as to why, after H1N1, our N95 mask depletion in the National Stockpile was down 75 percent, if the numbers that I am hearing are correct, and that they were never replenished? Is there any good reason why that is?

Mr. FUGATE. Yes. It was called sequestration.

Mr. CRENSHAW. Even though overall funding increased for the National Stockpile?

Mr. FUGATE. There were a lot of decisions made that it took time to rebuild. But we identified that the stockpile was only going to be a push package and that a pandemic would have to be augmented by production, purchasing, and ultimately the Defense Production Act.

Mr. CRENSHAW. OK. Sticking with you Mr. Fugate, does FEMA have the necessary authorities under the Stafford Act to respond to pandemics? Is there something you would change?

Mr. FUGATE. Yes. I would add pandemics to the definition of a major Presidential disaster declaration. Senator Collins actually tried to introduce this back in 2008, I believe.

There is also a Congressional Research report to Congress on whether or not FEMA can declare pandemics under the Stafford Act. Ultimately, it was always going to be a decision of the President, but because it is not listed, it tends to be a hindrance that it is not seen as FEMA's role to prepare for this.

Mr. CRENSHAW. One thing that has interested me as we sort-of have this National debate over response is I hear from States sometimes that they felt like there was not enough of a National plan, and then I also hear that they weren't given the flexibility they needed to, say, do their testing planning the way they would have liked to.

So as far as the State-Federal relationship, are we still basically on the right track? What lessons can we learn? What should be shifted in that relationship?

Mr. FUGATE. Having worked on both sides of this, I will tell you, I see the Federal Government as the rules and the tools and the funding. Then States, territories, and Tribes implement it to their specific constituencies. What works in Florida won't work in North Dakota. But we should be using the same standards and guidelines to implement those programs giving flexibility to the Governors and their teams for the implementation.

Mr. CRENSHAW. Would you say this? From my point of view that seems to be how it is always supposed to have happened and how it basically has been happening now, obviously, with some [inaudible] here and there.

Mr. FUGATE. Yes, I would agree. I think that I have heard calls for a Federal czar to take over and run all this, and I would defer to that. One person in the District of Columbia is not going to be able to make this work, but we need to have consistent guidance on the Federal side consistent with increased forces so that States can implement this as it is best for the States.

Ms. TORRES SMALL. Thank you.

Mr. CRENSHAW. I yield back.

Ms. TORRES SMALL. Thank you, Ranking Member.

The Chair now recognizes the Chair of the Subcommittee on Emergency Preparedness, Response, and Recovery, the gentleman from New Jersey, Mr. Payne, for questions.

Mr. PAYNE. Thank you, Madam Chairwoman. I would like to thank the gentlelady from New Mexico.

Mr. Fugate, it is once again good to see you. Always a pleasure. We appreciate your service to our country. It has been second-to-none.

As we all [inaudible] for disasters, do you believe that FEMA should retain the lead of the Federal Government's response to coronavirus, Mr. Fugate?

Mr. FUGATE. Yes, I was always—I found it fascinating when they put FEMA in that lead role, because if you think about FEMA, they are the ultimate support agency. Either we are supporting Governors in their response or we are supporting a lead Federal agency that has jurisdiction. In FEMA's history, this goes back to the Challenger disaster where FEMA was in support of NASA.

By putting FEMA in the lead role, I think we lost a lot of the expertise that CDC should have had that FEMA could have supported.

So I think FEMA's role as the Nation's crisis manager should be enforced, but I think it should also be seen that we want to make sure that the lead agencies with the jurisdiction, the legal authority, and the expertise are taking that lead and FEMA is supporting it and hopefully making them more successful.

Mr. PAYNE. Thank you.

Mr. Ghilarducci, same thing.

Mr. GHILARDUCCI. Yes, I will agree with Craig. I think that the topic area is that not necessarily FEMA being the lead agency but being the lead coordination agency at the Federal level.

Obviously, much like we have done here in California, our Health and Human Services is the lead agency dealing with the pandemic, but my office is providing the overarching coordination.

I bring all the other State agencies and departments together. I interface between the State and Federal Governments. I ensure that we are all rowing in the same direction so that we are not wasting time and we are not stovepiped in our effort or in our commitment of resources.

So that is really, I think, from the National perspective, FEMA brings a great role and they understand emergencies on a National scale. They have relationships with all the State directors and they go down to the local.

All disasters are local, and we have to look at it from that perspective, how these events are impacting local governments and State governments.

So I think that FEMA has got that ability to look at the big picture and make sure that action plans and the direction of the Federal Government are in the best interest and support of State and local governments.

Mr. PAYNE. Thank you.

Mr. Currie, what impact does constantly shifting who bears responsibility for response activity have on the Federal Government's ability to effectively manage a Nation-wide emergency?

Mr. CURRIE. Well, I think the roles and responsibilities being clear is critical in this case. I think, just to go off some of the prior responses to your questions, I think we were victims of past successes in other situations.

You know, typically in situations like H1N1 and Ebola and Zika and everything we have had over the last 50 to 60 years, HHS and

CDC have been able to handle the response to those public health emergencies.

So, because of that, the structures we have had in place to deal with public health emergencies and pandemics is focused on their role and their responsibilities, which is appropriate. They have the medical expertise necessary.

But what is clear in this case is they did not have the logistical capability that was required in a large pandemic.

So moving forward, I think the key is going to be for us to figure out what new structures and new processes and roles and responsibilities need to be in place to handle the rest of this pandemic, and hopefully we don't have one, but one in the future as well.

Mr. PAYNE. Thank you.

Also, Mr. Currie, how do you think deficiencies hindered FEMA's ability to properly develop and execute procurement strategy for COVID-19 given the scale of staff work on these issues? What is the No. 1 outstanding recommendation you think that FEMA needs to address?

Mr. CURRIE. Well, a couple come to mind in this case. The first is I will throw out the contracting issue, which has been a huge challenge. Chairman Thompson pointed this out in his opening statement. After Hurricane Maria, we had challenges trying to fill needs for tarps and other things.

So in a huge disaster this is very typical, where you have exhausted all your preexisting advance contracts and so you go out looking for anybody that can fill those things, and it is not surprising that you come across contractors that don't have the capability.

So I think we have got to get better in FEMA working with the States on advance contracting and existing contracts to handle these types of things, especially in a pandemic situation where cases are going up and down in certain places, more tests are needed in some places and less in others. It is a constantly-evolving situation and unless we have advance contracts that can scale where the need is [inaudible].

Mr. PAYNE. I know my time has expired. I yield back.

Ms. TORRES SMALL. Thank you.

The Chair will now recognize other Members for questions they may wish to ask the witnesses. As a reminder, I will recognize Members in order of seniority, alternating between Majority and Minority. Members are reminded to unmute themselves when recognized for questioning.

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

Mr. HIGGINS. Thank you, Madam Chairwoman and the Ranking Member and my colleagues on both sides of the aisle. It is wonderful to see you all, and I look forward to return to regular order where we can meet in person.

Madam Chairwoman, America's supply chains should be based out of long-term dependable trade partners in the United States or with stable, reliable nation-states based upon relationships similar to USMCA.

The dependability of our supply chains, especially as it regards to things like PPE in response to something like this we have

never seen before, this challenge that we are together overcoming one way or another is going to make us stronger, and I believe our supply chain is a primary example of that.

These supply chains should be multi-layered, in my opinion, and many of my colleagues agree, established by the Federal Government, by State and local governments, and by private business end-users that have, generally speaking, established a just-in-time, very efficient, economically efficient, but in response to a pandemic, where Nation-wide we need untold, previously-unimagined volumes of PPE, the just-in-time model just doesn't work.

Now, I must say that there have been some rather ugly things stated about our executive, who has responded, in my opinion, by rebuilding the Federal infrastructure. It has been incredibly re-envisioned and greatly enhanced over the last 6 months in a robust response to a new and aggressive virus born of China and knowingly released across the world as the Chinese Communist government concealed their actions.

President Trump and Vice President Pence have done an incredible job to literally rebuild America's pandemic response infrastructure. This is something we have never seen before. May I say that our President inherited a system that was set up by previous Presidents, not to blame President Obama and Vice President Biden, nor President Bush. But previous administrations had established a system that President Trump inherited and we just didn't see this coming as a Nation.

So I think it is fair to be critical, and it is our job to provide oversight, but let us take a step back from the political abyss that we stare at and give a fair evaluation of what our executive has done and how they have performed.

Ms. TORRES SMALL. Mr. Higgins, I deeply apologize. I would never want to interrupt your time normally, but due to technical issues we need to recess.

Members, please remain on the platform. The committee will stand in recess subject to the call of the Chair and your time will be restored.

Mr. HIGGINS. Thank you, ma'am.

Ms. TORRES SMALL. Apologies.

We are in recess.

[Recess.]

Ms. TORRES SMALL. The committee will reconvene.

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

Mr. HIGGINS. Thank you, Madam Chairwoman.

Let me say that I very much admire and greatly respect you. You have been the face of calm and reason during this technological challenge. It is very clear to me and to my colleagues on both sides of the aisle, I am quite sure, why the people of your district have placed their faith in you.

That being said, I am going to be submitting my opening statement and question in writing. I am being pulled to another Congressional obligation at this time. I will be yielding the balance of my time to the Ranking Member.

But before I do so, let me say that, despite the best efforts of our colleagues, I say again that I call upon the Majority to consider al-

lowing the House to return to regular order and voting in person. Let's step away from proxy voting and remote committee appearance. Because, again, despite the best efforts, the technology is not quite there yet.

I would say that we need to be in person regardless, but during a time of emergency, it could be foreseen that this is required. We have learned a great deal.

However, I will be continuously calling for the return to regular order. It is within the Constitutional parameters that I believe we should serve.

You have been fantastic during this hearing and this challenge. I apologize to our witnesses. I will be yielding the balance of my time to the Ranking Member.

I yield now.

Mr. CRENSHAW. Thank you, Representative Higgins. I couldn't agree more. I think the way you presented your case is exactly right. This not a hit on this subcommittee at all. This is a hit on the entire Congress. It has to stop.

We all know full well, we are all common-sense people, we all know that we could do this in person and show the American people that we have just a modicum of courage, just a little bit. It would be easy. We don't have to all congregate in there at the same time. Usually we don't anyway. Most of us watch from our office and then go in when it is our turn to ask questions. We could easily socially distance. We could wear masks. We could take all the proper precautions. We could easily do this. Yet, our House of Representatives has chosen not to.

This isn't the first time we have had technical problems. Of course we are going to have technical problems. Many other committees have it and we have had it in this committee as well.

Again, this is not the Chairwoman's fault. This is leadership from the top.

This is more than just about technical problems. It is about the ability to demonstrate to the American people that we have just a little bit of courage, just enough to actually show them that we are willing to take the slightest amount of risk just to do our jobs, so that we can actually hear our witnesses instead of the garbled robotic mess that it sounded like at times when I was trying to listen to them. We could actually do our jobs.

But we have sort-of reversed what it means to have a sense of duty in this country. Whereas it used to mean that we looked up to our heroes who overcame adversity and looked back on their hardship and said, "Look what I did, look what I overcame," now we seem to elevate victimhood as a virtue. We say, "Look at the problems we face. And look at us, we must hide. And that is virtuous, that is heroic."

It is not heroic. We look like fools. We need to stop. We need to do better.

We can easily do this. We all know how. We all know we could.

I think that we should be asking our leadership to put us back into Congress, in person. Stop the vote by proxy. We know we can do this safely. We have learned enough about this virus. We can do this by now. We could demonstrate to the American people that

we are in this together and that we are willing to do our duty and do our job. It really is as simple as that.

This is a highly unnecessary technical mess that we have involved ourselves in and I hope we stop.

I yield back the remainder of my time.

Ms. TORRES SMALL. Thank you, Mr. Ranking Member.

The Chair now recognizes for 5 minutes the gentlewoman from Illinois, Ms. Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair.

As a public health nurse, I have been disappointed and, quite frankly, horrified by this administration's failure to equip our health care professionals and others on the front lines of this pandemic with the supplies that they need to stay safe while doing their jobs.

Thirteen of my colleagues from the Illinois delegation joined my letter to the President back in March urging the administration to lead a coordinated National plan to procure and deliver PPE where it was needed most. Even in March, we were already getting tearful phone calls from Illinois nurses who had worn the same single-use mask for 5 days straight. This is unacceptable.

Yet somehow, 4 months later, we find ourselves still unable to obtain and distribute essential supplies to meet our basic needs. This is a colossal failure of leadership with truly life and death consequences.

I am glad our witnesses are here today to help us figure out what went so wildly wrong and to discuss improvements that need to be made.

Mr. Fugate, as you know, one of the most important supplies for health care workers is the N95 mask, which protects the wearer from inhaling the virus. In March, the White House promised to deliver 300,000 N95 masks to my State of Illinois. When the shipment arrived, the boxes were found to instead contain surgical masks, which are looser and do not provide anywhere near the same level of protection for the wearer as the N95 masks.

Based on your experience overseeing emergency management at the Federal level, what concerns does this type of mix-up raise for you about this administration's coordination of the National response to this pandemic?

Mr. FUGATE. Well, I don't think it is so much a mix-up, I think it is what they had available.

It goes back to my original concerns that in facing a novel virus, we never looked at how big the numbers needed to be. I think that is why we were not making decisions early on, such as increasing domestic production of N95 masks, reprioritizing that system. We just never took the steps to know how big is this.

We always, I think, adjusted based on what was available and tried to increase that, but we never got to what was going to be the big number, and so we still see those impacts today.

Ms. UNDERWOOD. OK. Thank you.

Illinois is currently in phase 4 of its data-driven reopening strategy. As more and more local businesses resume or increase their operations, and as we prepare to safely reopen schools this fall, we need PPE, and it is only going to continue to increase.

Mr. Fugate, how should the administration be preparing to meet the increasing need for PPE across the country?

Mr. FUGATE. Well, yes, I think it goes back to, what is the number we are planning against? How much domestic production can ramp up? What can our international supply chain supply? What is the difference of that or delta? Then what would we do to close that gap?

Again, we know that the N95s are most critical for health care workers. But for others, surgical masks or lesser grade protection is actually meeting the CDC guidance.

So it comes back to, what is the big number we have got to plan against? What is our capability domestically? What is our international supply capability? What is the difference? Then what steps can we take to close those gaps?

Ms. UNDERWOOD. In addition to the administration's own failure to provide the correct materials, another challenge our front-line workers and State leaders have had to contend with is fraud.

An investigative journalist at *ProPublica* broke a story last month about an operation that repackaged non-medical grade masks to remove the "medical use prohibited" warning and then they sold those repackaged masks to a Texas emergency manager for use in hospitals.

When the reporter contacted Homeland Security Investigations to ask about this case, his replied only that they are trying to, "determine if any violations exist or mishandling occurred".

Mr. Fugate and Mr. Ghilarducci, can you each expand on why the proliferation of fake equipment is so dangerous? What role does a successful Federal response play in preventing this?

Mr. FUGATE. Well, this goes back to when you have shortfalls in critical supplies people will attempt to use that to provide products that may not meet the standards.

As we saw with that investigation, in a grey market area it is not always clear what the violations were. If we had a better handle on domestic production and it was more regulated I think we could address some of these concerns.

But at the time that FEMA and others were going out procuring, there was not time to go out and do due diligence. Almost all of that was done electronically. So it wasn't until you actually had product showing up that in many cases you found out that it wasn't what the teams thought they were ordering.

Ms. UNDERWOOD. Well, at the end of the day scammers will take advantage of unmet consumer needs. Right now we see scammers providing everything from fake tests to useless PPE. Especially in the middle of a global pandemic the responsibility should not be on consumers to authenticate their PPE or tests.

With that, I yield back. Thank you.

Ms. TORRES SMALL. Thank you.

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

Mr. BISHOP. Thank you, Chairwoman Torres Small, very much.

I think I want to follow up, Mr. Fugate, on the questions Ms. Underwood just asked. There seems to be—and I had occasion to ask a question of Governor Pritzker about this—there seems to be a sort-of a chorus of condemnation of the administration for not

having an overall coordinated response. It seems to be mostly connected to the question of how much PPE has been available.

But you can't just wish PPE into existence and put it in the right spot. Isn't that correct?

Mr. FUGATE. That is absolutely correct.

Mr. BISHOP. You just explained in response to Ms. Underwood's question that having a quantity of PPE to meet a sudden huge need is a logistics problem, that you have got to get production capacity in place. If it is not sufficient, you have got to add to it. You have to figure out from a disparate number of economic actors across our economy and maybe the economy around the globe how to get items produced that don't currently exist and then get them delivered to the right place, correct?

Mr. FUGATE. Yes, sir.

Mr. BISHOP. Is it necessarily so that a Federal, any Federal administration, yours or the current one, faced with an unprecedentedly large demand that is sudden, is necessarily going to get that problem solved faster by taking control of the entire market through the Defense Production Act or the like?

Mr. FUGATE. When we war gamed what a pandemic looked like, that turned out to be our only option. It is a drastic tool. It has lots of disruption.

However, what we found was, because we had built a just-in-time health care system, it was going to take a draconian tool, like the Defense Production Act, to even begin to meet the needs, and then there was not going to be a rapid response to it.

So it would have to be turned on relatively early when their numbers often wouldn't justify that action, but by the time the numbers did, we were too far behind.

As we had explored this, this became one of the themes. Failure to turn on Defense Production Act early, your strategy now became one of hope you could meet demand. Turn it on early, you could meet demand, but if there wasn't a need for it, it caused a big disruption.

So it is not a precise tool. It goes back to the whole issue of there is no slack in the system for health care. That exacerbates what we are seeing now, that there wasn't even reserves to start with in most of the health care industry because everybody is just timing delivery, those stockpiles, they don't prepare for this, and the Federal Government became the default for this.

Mr. BISHOP. I appreciate your candor in having described that now a couple times, that the issue is one of many years in the making. I think it is unfortunately very counterproductive to go try to assess blame on that. The decisions are what they are. It is a resource allocation issue. It has existed for many, many years.

But let's take, for example, because it seems to persist, the notion, as you say, that using the DPA would be your only tool, but it wouldn't necessarily in the short term mean that you could be sure from that decision point at the beginning of the crisis that you were going to produce more in the short term by using that than in allowing market mechanisms to function. Isn't that so?

Mr. FUGATE. No, sir. Market mechanisms are why we are in the situation we are with a just-in-time delivery system. It is the most

cost-effective way to run it. It doesn't return to shareholders. An inefficient system would have had a lot more capacity to ramp up.

DPA actually does not start out with taking over manufacturing. The first thing, which was early on, DPA gives the Federal Government to go out and procure very large quantities and also prioritizes those products being domestically produced or coming into the country where they are needed most.

That can happen immediately with DPA. We used it during Superstorm Sandy to get interpreters.

So it is a tool that gives you immediate response if there is product there, and that ultimately gives you the ability to redirect industry to meet a strategic need that otherwise would not have been met if you only went to a driven capital system.

It hasn't built that capacity. There is no reason why you would have excess capacity unless you had some incentives, either through tax credits or guaranteed markets that required to you purchase that. It is not fair to industry to say you should solve this problem if we are not going to build in the tools to ensure production exists.

Mr. BISHOP. So you are talking about a long-term incentive solution, though, that would build more capacity to be in place over the long-term, correct?

Mr. FUGATE. Yes, sir. Pandemics are just one example of our global supply chain, the vulnerabilities we have in critical infrastructure when we depend upon global supply chains where the suppliers may not always share our views or interests.

Ms. TORRES SMALL. Thank you, Mr. Bishop.

The Chair now recognizes for 5 minutes the gentlewoman from California, Ms. Barragán.

Ms. BARRAGÁN. Thank you, Madam Chairwoman.

Thank you to our panelists for being here today.

As I have heard the testimony, I am a little surprised to be hearing so much of how wonderful the response was or how it couldn't have been done better.

I have heard and have read a lot differently. I have read a lot more about the administration's failures early on. In late January, we had Dr. Bright warning about the lack of PPEs, having to ramp it up quickly. Those calls went ignored. We had the President basically saying this thing was going to go away, it was going to disappear, making the mask very politicized.

So there have been a lot of failures with this administration, which is why I think it is so critical that we have these hearings and we make sure we don't repeat what has happened here, and that we be honest with the American people, because honesty will save lives. Even if we don't like what the outcome is going to be or what people's fears are, we have to address those.

I want to direct my first question to you, Mr. Fugate.

As part of the response to homelessness during COVID-19, FEMA has committed to reimburse 50 to 75 percent of expenses for shelter and temporary housing through the Public Assistance Program Category B. However, some local governments and agencies, like the Los Angeles Homeless Services Authority, have expressed challenges with the FEMA program, such as not knowing whether the program will be extended for the coming months.

Along the same lines, they have been told that it could take 4 to 5 years for localities to receive FEMA reimbursements.

Mr. Fugate, in your experience as the former administrator, is there anything FEMA could be doing to better notify localities if programs will expire or be extended?

Mr. FUGATE. Yes. This goes back to—and I am sure Director Ghilarducci can amplify this—is if FEMA is given the authority to extend this—again, these declarations are at the direction of the President, so the White House would have to concur—they could give guidance to States what the programs are, what the likelihood of being extended are.

As far as reimbursement goes, yes, it can be a long time. It can also be done in 2 weeks, which we did in Hurricane Isaac in the city of New Orleans for their overtime.

So FEMA doesn't have to take forever to move the money, but there has to be an understanding that the faster FEMA moves money, the greater risk there will be of errors and the potential that there may be a requirement to seek reimbursements back.

I think the other thing is the cost share is something that should be factored in, that it is 75 percent Federal, it is never going less than 75 percent. But the cost share going up to 100 percent may also be required in those jurisdictions that are seeing both impacts of COVID-19 demand as well reduction in income.

Ms. BARRAGÁN. Thank you, sir.

Along the same lines, last week the mayor of Tupelo, Mississippi, testified that they are still waiting on reimbursements from FEMA after a 2014 tornado caused major damage to the city. That was 6 years ago.

Can we expect localities to wait this long for FEMA reimbursements? How can we speed up the process to ensure that local governments quickly receive their reimbursements?

Mr. FUGATE. We were doing reimbursements and still doing reimbursements for Hurricane Katrina in New Orleans. In fact, in my last year at FEMA we were approving a million-dollar grant on a waste water treatment system, a waste water system.

So the rebuilding process is reimburse, ask, and build back. That can take a while.

I am more concerned about the immediate cost, which is protective [inaudible] response cost, that FEMA should be moving that money out very quickly. Congress has provided the funding.

But this may be something our friends at the General Accounting Office can weigh in on, is sometimes we get so fearful of making mistakes we slow the process down with bureaucracy instead of focusing on getting money out quickly and cleaning up later with controls in place. Sometimes there is just such a fear of making mistakes we end up holding so much process we never seem to get the money out quickly.

Ms. BARRAGÁN. Thank you, sir.

Mr. Ghilarducci, California was one of the first States faced with managing with the coronavirus, especially as it received repatriation flights and returning cruise ships when the outbreak began.

Can you tell us more about the evolution of your coordination with the Federal Government on response efforts? Did you notice a difference once FEMA took over as the lead?

Mr. GHILARDUCCI. Thanks for the question.

So California was engaged early on when the first repatriation flights were brought back in. We worked with the Department of State initially and then Health and Human Services agency first to set up our repatriation center in one of our airports in southern California, Ontario.

It became clear pretty quickly that that wasn't going to be sufficient. We needed brick-and-mortar facilities to keep people separated.

That was our first indication that the virus and the [inaudible] were happening in China and the repatriation members that were coming back could be potentially sick. So we worked to get brick-and-mortar barracks at March Air Force Base initially for the repatriation. That of course then extended into Travis Air Force Base in northern California and then Miramar Naval Air Station.

Ms. TORRES SMALL. Mr. Ghilarducci, I appreciate it.

I apologize, the gentlewoman's time has expired.

The Chair now recognizes for 5 minutes the gentlewoman from New York, Ms. Clarke.

Ms. CLARKE. Thank you very much, Madam Chair.

Let me thank our Ranking Member, Mr. Crenshaw, and Congressman Donald Payne, Jr. of New Jersey for the leadership that they are showing.

Let me thank our expert witnesses as well.

Being a New Yorker, I think that I have a very unique lens into the response of the administration. At the beginning of the COVID-19 pandemic I signed a letter calling on the White House to invoke the Defense Production Act to meet the shortfall of PPE and other official supplies—other critical supplies facing my district.

The people of New York City were hit first by this pandemic. As we cried out for PPE and ventilators, our pleas were met with a collective shrug from the administration.

By the time of the Defense Production Act, the limited way in which it was utilized, was finally invoked, frankly, it was too late.

As the case numbers begin to rise again across this Nation, we are once again finding this administration, I believe, asleep at the wheel.

We have had months to prepare, but comprehensive contact tracing is still far from a reality, and even basic supplies are once again in short supply.

For example, FEMA repeatedly touted Project Airbridge as a success story in accelerating the importation of critical PPE. FEMA has indicated that at least 50 percent of those supplies were directed to hotspot areas.

But there has been a serious lack of transparency to confirm this actually occurred. Despite repeated requests, we have yet to receive information on where the supplies went and other basic details, like how long it took to coordinate each flight.

You know, I will tell you that it is important to have this transparency, because we are getting word on the ground, particularly in the height of the pandemic, that FEMA was actually redirecting critically-needed supplies that were intended for one portion of the Nation to other portions of the Nation. I don't know whether that

is true or not, but having transparency about what took place would answer those questions.

So my first question is for Director Ghilarducci.

How effective was the Airbridge in helping to meet your State's supply needs? Were you given any insight into where these supplies went or whether a county in your State was deemed to be a hotspot for the sake of the program to better coordinate the State's efforts to surge PPE into communities?

Mr. GHILARDUCCI. Thanks for the question.

So Operation Airbridge eventually became a helpful tool. Initially it was not coordinated with the States. It was not communicated effectively. We did not know where PPE would be distributed to.

Quite frankly, the Airbridge effort actually enhanced the competition by which the States were having to deal with. In essence, Operation Airbridge cornered the market in any available PPE that we could possibly get.

So I think in the end, if it was a more coordinated and communicated effort and that PPE was brought in as a central capability that we could have all benefited by, it would have worked much better. But, unfortunately, it did not work that way.

Ms. CLARKE. All right.

Administrator Fugate, I want to echo the sentiments of my colleagues. We appreciate your years of service, your dedication, and your focus.

In many respects, as all of my colleagues have indicated, you were sort-of blindsided by the scope and breadth and depth of what we have had to deal as a Nation with respect to the coronavirus and its spread.

But how does Project Airbridge compare to your experience establishing public-private partnerships while at FEMA throughout your tenure?

Mr. FUGATE. Well, if you remember during Superstorm Sandy, one of our challenges was getting utility trucks into the area quickly. President Obama held a conference call with utility companies. He said, if we have got equipment on the West Coast, but it's going to take us a week or more to get it to the East Coast, can you call us?

So FEMA coordinated with the Defense Transportation Command. We used C-17s from the time of that call to the first touchdown of those trucks. It occurred within 24 hours.

So we have worked with the private sector. In fact, we look at the private sector as part of the team. We have used [inaudible] assets, including DOD assets, to move equipment from the private sector to achieve an outcome, which was getting utilities turned on faster in Superstorm Sandy.

Ms. CLARKE. Very well. I yield back. I thank you, Madam Chair, for this very timely hearing. These important findings will make a difference in life and death across this Nation. I thank you, and I yield back.

Ms. TORRES SMALL. Thank you Congresswoman Clarke.

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

Ms. JACKSON LEE. Thank you very much, Madam Chair, for your kindness and generosity in yielding to me. I am here in one of the

major hotspots of COVID-19, and we are not really seeing an end, which I think is the uniqueness of COVID-19, is that both science and medicine have now understood that it is not a virus that they control. The virus controls us.

But we know that the basic elements of it are the initiatives that we had, are cleanliness, sanitizing, gloves. Eyewear has come into play, as I am wearing right now. Masks and mandatory mask orders.

But we also know that in the system of logistics and equipment we suffered greatly in being prepared. We suffered greatly with no PPEs. We were fighting—and I really mean it—fighting for masks. We were seemingly on markets that were impossible to penetrate in terms of trying to get PPEs.

Of course the big one was test kits, test kits, test kits. I would hear from my colleagues across the Nation: “Where are the test kits? I can’t get any.”

Administrator Fugate, we have worked together in the past over the years with hurricanes. I think, if I know you well, your key definition is preparedness.

I would like to hear again, in light of Texas over 235,000 cases, now moving up to 6,000 deaths here in Houston, 60,000 [inaudible] and the number of deaths that we have as our numbers continue to grow. I have a hospital right now where we are getting the military team not in the hospital, but working through a hospital where a military team will be coming to add to our needs here in terms of staffing.

Administrator Fugate, can you speak to the absolute crucialness of strategic plans, particularly on unknown disasters like a COVID-19, and the importance of early on developing a plan for equipment, which would include please testing, which I understand that people in Florida right now are fighting to get tests?

Mr. FUGATE. Thank you, Congresswoman.

You know, it may sound trite, but what I have learned in disasters is by the time you know how bad something is, it is a little late to achieve the outcome. I learned this a long time ago and it is a simple process. It may sound trite but it works for me.

First thing is, define the disaster, think big. Don’t try to wait until you have all the information, just go, how bad could it be? Then continue to go big. You have got to start ordering your resources and personnel for that event and looking at shortfalls and capacity. You need to go fast. The more precision, the better you wait for information, the slower you get.

The last part is be smart about it. As the numbers start coming in, adjust. Hopefully you are adjusting downward. But you never get time back in a disaster.

Again, as far as this being unforeseen and unprecedented, I actually helped set up an exercise back in January in the State of Florida, a no-notice exercise on COVID-19.

I think we have had a lot of missed opportunities. I think this has gotten to a point where nobody wants to talk about what didn’t work.

I think we also need to consider something like a National Transportation Safety Board-style committee that is standing, that is not partisan, to review these types of events, to learn lessons so

they don't become lessons observed but are actually then implemented in the changes to change future outcomes.

Ms. JACKSON LEE. Administrator, if I could very quickly, my research and testimony that I secured in the Homeland Security Committee hearing was that the administration actually was aware of COVID-19 as early as October 2019, which means we should have long since had some kind of discernible plan.

But there are two issues that I would like your comment on. I know already that you are not an educator but a great public servant.

The issue of tests, test kits, that became almost of crisis proportion with people really literally in the streets trying to beg for test kits, trying to get States to get test kits. It was unbelievable. We are now with lines of people in different cities trying to get test kits.

It emphasized when you have something that is so strategically important to fighting back the disaster which is COVID-19, how important it is to get ahead of that.

Then any comment on what elements we should look at as school districts across the Nation want to do the best thing for their students in light of the circumstances that you see. You are not a physician, I know that, but in terms of being prepared.

Thank you. Thank you for your service.

Mr. FUGATE. The test kits are really critical if we can get containment. When we are seeing the infection rates we have now, I don't think testing is going to change the outcome. If we get containment and then we can test people and isolate people that are exposed, we will get this under control.

But if we can again go back to [inaudible]. How big and how much would you need in a worst-case scenario? Not what the plan says, not what you think you are going to need, but just go, "How bad could this be?" and then start working backward.

Ms. TORRES SMALL. Thank you, Mr. Fugate.

Ms. JACKSON LEE. Thank you for the courtesy.

Ms. TORRES SMALL. Thank you, Congresswoman.

I so appreciate everyone's patience in the midst of all of this. I know we have a hard out at 12:30.

So I just want to close by thanking the witnesses for their valuable time, patience, and testimony.

I want to thank all the Members for their questions, patience, and dedication to serving their districts. I deeply respect my colleagues and I do not judge any differences we may have in opinion for a lack of courage in the way they serve during this crisis that we face together.

The Members of the subcommittee may have additional questions for the witnesses and we ask that you respond expeditiously in writing to those questions.

Without objection, the committee record shall be kept open for 10 days.

Hearing no further business, the hearing stands adjourned.

[Whereupon, at 2:28 p.m., the subcommittees were adjourned.]