Congress of the United States
Washington, DC 20515

April 21, 2020

The Honorable Mike Pence
Vice President
Presidential Coronavirus Task Force

The Honorable Alex M. Azar II
Secretary
Department of Health and Human Services

Rear Admiral John Polowczyk
Supply Chain Task Force
Federal Emergency Management Agency

The Honorable Robert R. Redfield, M.D.
Director
Centers for Disease Control

Mr. Peter Navarro
White House Trade Advisor

Mr. Jared Kushner
White House Advisor

LTG, U.S. Army, Darrell K. Williams
Director
Defense Logistics Agency

Dear Trump Administration Supply Chain Managers:

We are deeply concerned by the federal government's COVID-19 supply chain management response. Insight from congressional communication, local hospitals, states, and media reporting describes disorganized, dysfunctional supply chain management from the federal government. A pandemic is a unique national security circumstance**.** It is imperative that our federal engagement help, rather than hinder, our national response to the coronavirus.

A "Wild West" free market

Emergency preparedness and response experts stress the importance of the federal government taking the lead to ensure medical supplies are available and distributed where they are needed most. Instead, this Administration has directed states, local governments, and hospitals to buy their own supplies, not depend on the federal government, and has even insisted that they are not to blame for any shortfalls.[i] In addition, Mr. Kushner indicated at a White House press conference that contrary to its founding intent and statutory language, the strategic national stockpile is not to be considered a resource for States.[ii] But even before these explicit communications, states were receiving insufficient resource support from the federal government and had to take the initiative to supply themselves.[iii]

As hospitals and sub-federal entities are left to find their own supplies to support pandemic-level demand, they must compete in a resource-scarce market against each other, driving up prices for everyone.[iv] This environment pits resource-rich entities against poorer entities; rich states against poor states; hospitals against states; states against other countries; and those desperate against everyone else. This is further complicated by the fact that states and sub-national entities lack the purchasing power, logistical power, or ability to run a deficit like the federal government. Thus, this inadequate, fractured system disadvantages the overall United States' COVID-19 response.[v]

This global emergency is too big and complex to be left to the country's free markets. As hospitals and providers pay exorbitant prices or resort to unorthodox maneuvers to get the vital

equipment that they need and as the federal government offers little to help control the market, some governors are starting to tackle the problem on their own, forming partnerships and connecting procurement teams to work together to buy personal protective equipment in bulk, rather than compete against each other and drive up the prices. [vi] Functionally, governors have been forced to create quasi-federal logistics management in order to harness American manufacturing and make sure materials get to the right states at the right times and at a reasonable rate.

Questionable federal involvement

Not only governors, but distributors, hospitals, and public health experts also report concerning engagement from the federal government. They report bidding against and losing out on contracts to federal agencies, who they are unable to compete with financially, and whose competition inherently drives up prices. They also report the federal government is confiscating shipments.[vii] In addition, no information has been provided on whether the items were confiscated for failure to meet safety standards or whether the federal government redirected the supply. Once seized, there is also no guidance from the federal government about how or if individuals will get access to the supplies they ordered, leaving states and counties frustrated and unable to secure a reliable supply chain. This has stoked concerns about double purchasing – once for the confiscated supplies and a second time for the same supplies from a distributer after relayed to them by the Federal government. These actions exacerbate supply chain dependability fears – hospitals and labs cannot depend on their supplies until they physically see them. Unfortunately, because of a lack of a centralized supply chain, and little federal coordination where help is needed, there is no coherence to alleviate these fears.

In addition, despite billions of dollars of taxpayer money dedicated by legislation for supplies, there is little understanding of federal government acquisitions and distributions, no public reporting, and continued unmet demand. From the information we do have about the Strategic National Stockpile, we know that states received at least three shipments of personal protective equipment and supplies, and a few states received an additional fourth shipment.[viii] According to the Department of Health and Human Services (HHS), these shipments were not made based on states' requests; the first two shipments were allocated pro rata based on 2010 Census population data, and the third shipment, labeled the "final push", was not based on population. When HHS staff stated that the Trump Administration made its final shipments of personal protective equipment from the Strategic National Stockpile, there was concern that there will be no further new federal acquisition and distribution to shore up communities in need.[ix]

Moreover, when there is federal purchasing, thus far it has been reported as insufficient or unhelpful.[x] It has also been well documented that the federal government wasted months before preparing and purchasing domestically.[xi] The administration ordered 10,000 ventilators in late March, far short of what public health officials and governors said was needed.[xii] In a House Oversight and Reform Committee briefing, top Federal Emergency Management Agency officials mentioned that 100,000 ventilators would be available by late June at the earliest, when models expect the pandemic to be receding.[xiii]

Also, at the beginning of the pandemic, HHS stated that the United States had about one percent of the required respirator masks on hand that would be needed for medical professionals if the COVID-19 outbreak were to erupt into a pandemic. At the time, HHS pandemic planning

assumptions estimated the U.S. health care system would need up to 3.5 billion N95 respirator masks over a year. Despite this, the Oversight and Government Reform Committee found that only 11.7 million N95 respirator masks have been distributed nationwide. In addition, we know that HHS has only planned to use some of the federal money to purchase up to 500 million N95 respirators over the next eighteen months, well short of the 3.5 billion needed this year and far too late for peak needs. We need that supply now. Unfortunately, federal contracts with 3M don't require deliveries to the national stockpile until the end of April, after the White House has projected the pandemic will reach its peak.[xiv] This is too late for the Community Health Centers that have already closed due to the lack of N95 respirators and it is too late for hospitals on the frontlines experiencing workforce shortages because of COVID-19 positive staff, a result of lack of PPE.

Engagement on the International Stage

In addition to concerning reporting on internal domestic competition, there are consistent, unflattering reports of the U.S. sparring with other countries for supplies, and even hijacking shipments of masks and additional crucial supplies meant for other countries, including U.S. allies.[xv] A report from *The Guardian* found that American buyers wrested a shipment of masks from China that was supposed to go to France by offering three times the selling price.[xvi] In another, a German official accused the U.S. of an "act of modern piracy" after a shipment of masks from China to Berlin was seized and diverted to the U.S.[xvii]

This is a *global* pandemic. Success in eliminating its threat will require not only that we prevent it's spread in the U.S., but internationally as well. A strategy document crafted by the State Department and the U.S. Agency for International Development recognized mitigating the virus in poorer countries as "critical for the safety and security of the American people."[xviii] Developing countries, without the resource power and infrastructure to manage COVID-19, are likely to be left behind in the race for personal protective equipment, potentially exacerbating and extending the crisis. If poorer countries are unable to stop the virus, it is more likely to reemerge in more developed parts of the world. Instead of recognizing those needs, this administration announced it will halt funding for the World Health Organization and asked international aid groups to share supplies with the U.S. government, a reversal of the usual dynamic between the world's leading power and those it typically helps.

Increasing the federal response

While the Federal Emergency Management Agency (FEMA) acknowledges that the Strategic National Stockpile alone cannot fulfill all requirements and that the federal government will exhaust all means to identify and attain medical and other supplies needed to combat the virus, it is concerning that the role FEMA is playing is simply as a courier. FEMA's "Project Airbridge" is running flights to expedite the sourcing of personal protective equipment, but then placing the supplies back into the traditional commercial supply chain, functionally only expediting transportation. That has caused concern that the taxpayer expense to finance the location and transportation of *new* supply is wasted since FEMA places those supplies back in the hands of traditional distributors, forcing domestic competition for the product.[xix] In addition, FEMA is not directing private sector suppliers to send supplies to particular hospitals with urgent needs,

instead they are only requiring distributors to agree to sell half of their shipments to customers in "hotspots," with no clarity on what is considered a hotspot.

The world's supply of N95 masks and other basic medical supplies are made in China, and China has only recently resumed exports as it comes out of its peak of the pandemic in-country.[xx] This supply chain vulnerability highlights the need to not only expedite imports from China in the near term, but also diversify imports while building up domestic capabilities. We need to be able to ramp up manufacturing in countries that have not been hit as hard by the pandemic, as well as build up capacity domestically to meet our internal needs, and then our international obligations as a humanitarian leader. Beyond the buzzwords "Preservation, Acceleration, Allocation and Expansion," very little meaningful information has been provided on what the Administration is doing to diversify and increase supply.[xxi]

Despite overseeing the supply chain taskforce, FEMA is not modelling supply needs, instead depending on hospital supply chain projections, and then using different metrics to make allocations.[xxii] Relying on hospital supply chain projections when they can barely count on their own supplies due to the incoherence of the supply chain not only yields imperfect needs calculations but is also limiting in terms of the universe of those in need of supply. The Institute for Health Metrics and Evaluation developed a series of models to gauge the capacity of the health care system to handle the pandemic surge.[xxiii] This is one of many academic models, but the most widely used and cited, which shows that there are still significant national shortfalls.[xxiv]

We do not have enough supply to meet demand, even when accounting for expedited importing and a surged traditional private sector supply chain. More domestic production is needed to meet our needs. In mid-January, Robert Kadlec, Assistant Secretary for Preparedness and Response at HHS, instructed subordinates to draw up contingency plans for enforcing the Defense Production Act (DPA), as it enables the government to compel private companies to produce equipment or devices critical to the country's security.[xxv] However, despite desperate need, use of the DPA or federal engagement to help develop new production has been sparse. That has left campaigns like Project N95 or Stop the Spread to fill the federal void in ramping up domestic supply. Stop the Spread connected General Motors and Ventec to begin manufacturing ventilators.[xxvi] Only after a commitment was made did the Administration enact DPA to solidify the agreement with federal purchasing.[xxvii] Similarly, only after 3M already made voluntary commitments to increase production did the Administration invoke DPA.[xxviii] This has been a consistent theme of DPA usage and federal action, an unwillingness to use federal authority to work outside of the existing supply chain or voluntary engagement.

Given these concerns about the management of the supply chain, please respond to the following by May 5, 2020:

- Beyond expediting transportation, what is the federal government doing to identify and attain new medical and other supplies needed to combat the virus?
- Please publicly report federal purchasing and distributions related to COVID-19. In addition, please publicly disclose the prices paid for supplies, including, but not limited to, N95 respirators, face shields, surgical masks, surgical gloves, isolation gowns, booties, lab supplies, medical drugs, and other equipment during the pandemic, as well

how the distributions are being allocated, how many are new acquisitions over tradition supply, and what supplies are going to what states.

- What are the HHS pandemic planning assumptions of estimated U.S. health care needs? For example, out of an estimated need of 3.5 billion N95 respirators, how many masks have been circulated?
- How is the federal government ensuring medical supplies are available and distributed where they are needed most? In addition, please define "hotspots" and clarify the methodology for determining a hotspot.
- How are you working with distributors to allocate resources?
- How will you work to ensure you are not competing for resources with sub-national entities?
- Why is there not a federal buying clearinghouse? Was a decision made against setting up a federal buying clearinghouse?
- What are you doing to help control the price of these scarce resources?
- According to FEMA, there is a FEMA-Department of Health and Human Services-Department of Defense system for identifying needed supplies from vendors. Are you making this tool available for sub-national entities looking for supplies?
- How are supplies being acquired and funneled to the DOD?
- What conversations are happening to address supply concerns in other countries? In addition, how are you coordinating with other countries to increase their ability to combat the virus?
- Once U.S. supply needs are met, how will you we work to support international supply?
- What conversations is the U.S. having about diversifying manufacturing sourcing in other countries?
- In addition to hospital projections, what modeling are you using? How are you using it and incorporating modeling into action?
- What guidance has been given to States on modeling?
- Why has the Administration not fully invoked the authorities under the Defense Production Act?

Sincerely,

Donald S. Beyer Jr.
Member of Congress

/s/
Gerald E. Connolly
Member of Congress

/s/
David E. Price
Member of Congress

/s/
Bill Pascrell, Jr.
Member of Congress

/s/
Terri A. Sewell
Member of Congress

/s/
Jimmy Panetta
Member of Congress

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