CONFRONTING THE CORONAVIRUS: THE FEDERAL RESPONSE

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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CONFRONTING THE CORONAVIRUS: THE FEDERAL RESPONSE

Wednesday, March 11, 2020

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

The committee met, pursuant to notice, at 2:19 p.m., in room 310, Cannon House Office Building, Hon. Lauren Underwood, presiding.

Present: Representatives Thompson, Lee, Richmond, Rice, Correa, Torres Small, Rose, Underwood, Slotkin, Cleaver, Green, Clarke, Titus, Watson Coleman, Barragán, Demings; Rogers, Katko, Walker, Higgins, Lesko, Joyce, Crenshaw, Guest, Bishop, Van Drew.

Ms. UNDERWOOD. The Committee on Homeland Security will come to order. The committee is meeting today to receive testimony on the Federal response to the coronavirus.

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

Good afternoon. Today, the committee is meeting to examine the Federal Government response to the novel coronavirus pandemic.

As a nurse, I want to open by encouraging everyone to visit coronavirus.gov for the most up-to-date information from the Centers for Disease Control and Prevention—and take care to practice habits that will keep us all safe. Wash your hands often with soap and water or use hand sanitizer. Don't touch your face. Cover your coughs and sneezes. Avoid close contact with others if you or they are sick.

We know that the spread of coronavirus has likely not yet reached its peak, and it is affecting all of our communities. I don't think there is a person in this room who isn't worried about an elderly or immunocompromised relative's health, a friend's job, or a child's school closure.

Just yesterday the first 2 cases were diagnosed in the counties that I represent in Illinois. Our jobs as Members of Congress is to keep Americans safe by working with the Executive branch to lead a strong Federal Government response, including the House-led $8.3 billion supplemental funding package that passed last week. A strong response must include each of these 3 elements.

First, we must continue to support our local and State public health departments, our health care system, our emergency responders who are at the front lines of this outbreak.

This starts with having reliable data to make decisions, like how to prepare for a surge to our health system and how much personal protective equipment is needed for health workers.

It also means developing and disseminating clear, accurate risk communication to the public. America's scientific and public health expertise is unmatched throughout the world, and it must be driving our decisions.

Second, we must protect people from health care costs associated with the coronavirus. Testing and treatment must be widely available at no cost to patients. Price gouging of medical essentials and other supplies must be stopped.

If we do not take these crucial steps, the epidemic will worsen because families will avoid seeking care for fear that they can't afford it. Our communities will be less safe.

Third, we must soften the economic impact of this crisis on American families and small businesses. This means paid sick leave for every worker, unemployment insurance, and food assistance if needed.

Given the committee's jurisdiction, today we will also examine the Department of Homeland Security's role in the coronavirus response effort. The Department plays a key role in protecting workers on the front lines of this outbreak, processing travelers entering the United States and referring them for screening by health care workers as necessary.

We will have questions today about the efficacy of this screening and how it is being performed at our air, land, and seaports. We also want to learn more about the Department's ability to protect its own workers, whether it has adequate personal protective equipment for front-line personnel such as Customs and Border Protection officers, Board Patrol agents, and Transportation Security officers.

Finally, we want to hear about what plans the Department has to ensure continuity of operation at certain essentially facilities in case of outbreaks there such as ports of entry, TSA checkpoint, and immigration detention facilities.

Today, we are joined by Mr. Ken Cuccinelli who is currently serving as the senior official performing the duties of deputy secretary of Homeland Security to respond to these important questions. Mr. Cuccinelli is also the Department's representative on the White House Coronavirus Task Force. I hope to hear from him about the work of the task force this afternoon.

He is joined by Doctor Stephen Redd, a medical doctor and epidemiologist with decades of experience with the Centers for Disease Control and Prevention. It is my understanding that Doctor Redd was due to retire this month, but he has agreed to stay on to assist with the coronavirus response.

We thank you, sir, for your dedication and service to our country, and thank both of our witnesses for being here with us today. I look forward to a productive dialog with my colleagues and our witnesses today.

[The statement of Vice Chairwoman Underwood follows:]

STATEMENT OF VICE CHAIRWOMAN LAUREN UNDERWOOD

MARCH 11, 2020

Today, the committee is meeting to examine the Federal Government's response to the novel coronavirus outbreak. We know that the spread of coronavirus has likely not yet reached its peak, and is affecting all of our communities. Just yesterday, the first 2 cases were diagnosed in the counties I represent in northern Illinois.

Our job as Members of Congress is to keep Americans safe by working with the Executive branch to lead a strong Federal Government response, including the House-led $8.3 billion supplemental funding package that passed last week. A strong response must include each of these 3 elements: First, we must continue support for our local and State public health departments, our health care system, and our emergency responders who are on the front lines of this outbreak. This starts with having reliable data to make decisions, like how to prepare for a surge to our health system, and how much personal protective equipment is needed for health workers. It also means developing and disseminating clear, accurate risk communication to the public. America's scientific and public health expertise is unmatched across the world, and it must be driving our decisions.

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Third, we must soften the economic impact of this crisis on American families and small businesses. This means paid sick leave for every worker, unemployment insurance, and food assistance if needed. Given the Committee's jurisdiction, today we will also examine the Department of Homeland Security's role in the coronavirus response effort. The Department plays a key role in protecting workers on the front lines of this outbreak, processing travelers entering the United States, and referring them for screening by health care workers as necessary. We will have questions today about the efficacy of this screening and how it is being performed at our air, land, and sea ports. We also want to learn more about the Department's ability to protect its workers, and whether it has adequate personal protective equipment for front-line personnel such as Customs and Border Protection officers, Border Patrol agents, and Transportation Security officers.

Finally, we want to hear about what plans the Department has to ensure continuity of operations at certain essential facilities in case of outbreaks there, such as ports of entry, TSA checkpoints, and immigration detention facilities.

Ms. UNDERWOOD. The Chair now recognizes the Ranking Member of the full committee, the gentleman from Alabama, Mr. Rogers, for an opening statement.

Mr. ROGERS. Thank you, Madam, Chairman. I want to thank the witnesses for their presence and for your preparation. I know it takes a lot of time and effort to be here and prepare for it. We appreciate that. It is very helpful to this committee.

As I said last week, our hearts go out to those who have lost loved ones and to those who are currently undergoing treatment. This is a global event and requires a global response. Our country has faced outbreaks of serious disease in the past. In each case, we have martialed our collective resources and ingenuity to overcome these crises. I am confident that will be the case with COVID–19.

Congress has worked closely with current and past administrations to prepare for outbreaks just like this. Last summer, the President signed into the law The Pandemic and All Hazards Preparedness Act to enhance Government authorities and authorize funding for emergency response and medical countermeasures.

Since 2015 under Republican leadership, we have increased funding for infectious disease response by 70 percent. Just last week, we came together in a bipartisan fashion to provide over $8 billion to help keep public officials able to respond to this crisis and expediate the development of a vaccine.

I hope the spirit of bipartisanship will continue as we look at ways to sure up the economy in the wake of this crisis. But I am concerned about the petty political attacks on the administration's response, such as the Majority's attack on the Vice President.

The bipartisan commission on biodefense as well as the panel of health experts that appeared before us last week agreed that the Vice President should be the one leading the response. The Vice President is the only one with a direct line to the President and the authority to achieve a whole-of-Government coordinated response to this outbreak.

Unlike the Ebola czar named under the Obama administration, the Vice President is in the chain of command, and he didn't lobby for the pharmaceutical industry. Last week we heard from a panel of medical experts who all agreed that the Government is doing the best they can under the circumstances.

Today, we had the CDC and the Department of Homeland Security here to talk about their response efforts. I am interested in hearing how the agencies are using the supplemental funding Congress provided last week as well as what additional authorities they need to effectively respond to this crisis.

In the middle of a crisis like this, it is very important for political leaders to avoid flaming the fire of hysteria. Our job should be to support the response effort and to provide the public with accurate and timely information to keep them safe.

I encourage everyone to heed the advice of our medical professionals and our Chairwoman. Wash your hands. Stay home when sick. Visit the Center for Disease Control and Prevention's website for updated information.

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

[The statement of Ranking Member Rogers follows:]

STATEMENT OF RANKING MEMBER MIKE ROGERS

MARCH 11, 2020

As I said last week, our hearts go out to those who have lost their loved ones and those who are currently undergoing treatment.

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In the middle of a crisis like this, it is very important for political leaders to avoid fanning the flames of hysteria.

Our job should be to support the response effort and provide the public with accurate and timely information to keep them safe.

I encourage everyone to heed the advice of our medical professionals—wash your hands, stay home when sick, and visit the Centers for Disease Control and Prevention's (CDC) website for up-to-date information.

Ms. UNDERWOOD. The Chair now recognizes the gentleman from Mississippi, Mr. Thompson, for an opening statement.

Chairman THOMPSON. Thank you very much. I appreciate the Vice Chairwoman's handling of the meeting today. I have some talking problems so I will be short. But let me say the witnesses we had last week said absolutely we have to have effective communication in a situation like this. People have to tell the truth.

Well, I will just say some of the things that we have heard in the past. The President called the Governor of the State of Washington last week a snake. Well, that State has been the most heavily hit State during this crisis. Our President just can't call another Governor a snake.

Then in the same sense, the Vice President turned around and said he is one of the best people doing the job addressing it. So I think communication and how you outline this is very, very important.

When this issue first came up, a lot of people said it was a Democratic hoax. It was never a hoax. We have video where people said it. It just should not be.

So in the interest of getting and addressing this problem, taking a whole-Government approach, I would encourage us to deal with the facts. But it starts at the top. If the top is calling names, people have to respond. I think going forward if we can agree that we will not call names, we will address the issue.

A lot of communities are concerned from New Jersey to New York to Texas all over. Everybody is being impacted. Most of us who came to Washington this week, there were a lot of empty plane seats on those planes coming to Washington because people don't feel comfortable in terms of flying.

Some of the people on the planes have masks. We have been told by professionals the masks really doesn't address the problem. So I would hope, Madam Chair, that with our experts here today we will hear the facts.

With that, I yield back.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

MARCH 11, 2020

Last week, the committee held a hearing with non-government expert witnesses to examine the Federal response to the coronavirus and assess what more must be done to address this pandemic threat.

Today, the committee will hear from representatives from the Department of Homeland Security and Centers for Disease Control on the issue.

Since our last hearing, I have become increasingly concerned about the threat posed by the coronavirus and the Trump administration's lack of urgency necessary to mitigate the harm it poses to Americans.

Test kits have been slow to roll out, masks and personal protective equipment for health care workers are in short supply, and even basics like hand sanitizer are hard for consumers to find. We are clearly behind the curve, and it will take a concerted whole-of-Government effort to catch up. As President Trump's own former Homeland Security Advisor Tom Bossert recently put it, "it's now or never" if we are to get the coronavirus under control.

I hope to hear today from our witnesses about what those steps might be, including whether limiting mass gatherings, temporarily closing schools, or restricting certain travel may be necessary.

I also expect to hear from Mr. Cuccinelli about the work of the White House Coronavirus Task Force and how he intends to make sure the administration moves more quickly to help protect the American people confront the coronavirus.

Finally, I want to know what the Department of Homeland Security is doing in its role to protect the public and its own work force. The coronavirus is here. We cannot change that. What we do in the coming days and weeks will determine what comes next for our country.

Congress has already shown its willingness to support the response with the recent emergency supplemental appropriations bill.

Our hearing today is another important part of our work, as we fulfill our Constitutional oversight responsibilities.

I certainly hope the administration is up to the task. The American people are counting on it.

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

[The statement of Hon. Jackson Lee follows:]

STATEMENT OF HONORABLE SHEILA JACKSON LEE

MARCH 11, 2020

Chairman Thompson and Ranking Member Rogers, thank you for this opportunity for holding today's hearing on "Confronting the Coronavirus: The Federal Response."

I thank today's witnesses and look forward to their testimony:

- Ken Cuccinelli, senior official performing the duties of the deputy secretary, Department of Homeland Security (DHS) and the DHS representative on the White Coronavirus Task Force:
- Stephen C. Redd, MD (RADM, USPHS), deputy director for public health service and implementation science, Centers for Disease Control and Prevention (CDC).

Today, the World Health Organization, declared that COVID–19 to be a pandemic, which has reached at least 114 countries, sickening over 100,000 people, and killing more than 4,000.

My thoughts and prayers are with the families who have lost a loved one to the coronavirus, and the many others who have contracted the disease.

COVID–19's infectiousness ratio is 2.3, while the flu is 1.5, making it much more infectious than the flu.

People can pass the illness along with few symptoms.

TESTING FOR COVID–19

For these reasons, the Nation's testing for the virus must improve.

While the United States has produced 75,000 tests, South Korea has tested over 200,000 persons and can perform 11,000 tests a day.

Testing is the only way to fully understand community spread of COVID–19.

Currently tests, because there are so few available, are limited to people who have traveled to areas where the virus is experiencing community spread or if the person is symptomatic.

Limiting access to testing must end because communities, States, and the Nation cannot plan a counter offensive to stop the spread of COVID–19 without knowing who is and who is not infected.

HOUSTON AREA'S FIRST PRESUMPTIVE POSITIVE TEST OF COVID–19

The first presumptive positive COVID–19 case in Texas was reported this week to have occurred in Montgomery County Texas, which borders Harris County, the location of Houston, Texas.

Montgomery County, Texas officials confirmed that the man has not traveled out of the State or country recently.

Currently, everyone he has been in close contact with is in self-quarantine.

If the case is confirmed by the CDC, this could be the first community-spread case in the Houston area.

The Houston area has other cases that are linked to travel outside of the State, but this is the first case not linked to travel outside of the State.

The Montgomery County Community has taken steps to protect children by closing schools 2 days before spring break to do a deep clean, and they are expecting to resume classes after the break.

The person is being treated at an undisclosed hospital and is reported to be under observation and doing well.

We owe a special debt to First Responders who will be the lifeline for many people who will need medical care to overcome novel Coronavirus (COVID–19).

A VACCINE

I have received reports that the Baylor's College of Medicine has a vaccine for COVID–19.

We cannot delay in seeking confirmation on this report and, if true, set into motion the processes necessary to produce enough vaccine to inoculate the American people.

Even if Baylor has a cure it will take a year to grow enough vaccine to treat people at risk of contracting COVID–19.

WHO

On March 3, the World Health Organization sought to differentiate the spreading novel coronavirus from influenza, with the underlying message that while seasonal flu cannot be stopped, countries still have the chance to limit cases of COVID–19, the disease caused by the new virus.

WHO said the Coronavirus is not SARS, MERS, or the flu.

COVID–19 is a unique virus with unique characteristics that scientists, and virologists, and researchers around the world are racing to understand.

We have a window to escape the worst of this disease's impact on our world, but that window is closing.

A critical tool in the arsenal for stopping COVID–19 is the Department of Homeland Security and, more specifically, the men and women who are on the front line at our Nation's airports and borders.

The Department of Homeland Security has a vital mission: To secure the Nation from the many threats we face.

This requires the dedication of more than 240,000 employees in jobs that range from aviation and border security to emergency response, from cybersecurity analyst to chemical facility inspector.

But we cannot forget that they too are vulnerable to the Coronavirus.

We must protect DHS personnel and their families, while they fulfill their vital mission of protecting the American people as we fight the spread of COVID–19.

EBOLA LESSONS LEARNED

In 2014, the world had a close call with the Ebola outbreak that took the lives of so many, and reached U.S. soil, when Eric Duncan arrived from Liberia for visit with his family not knowing he was infected.

When Mr. Duncan went to an Dallas area hospital for treatment for the symptoms of Ebola he was denied admission, but after returning a few days later he was admitted and later died.

That battle with Ebola lasted from 2014 until 2016.

It took thousands of researchers, doctors, nurses, public health professionals, and volunteers who worked for over 2 years to win that war against Ebola.

To win that war we fought the disease close to its place of origin.

We could not afford to lose that fight because that would risk Ebola becoming endemic, meaning that it could be contracted in many Nation's around the world.

President Obama and bipartisan leadership in the House and Senate made the difference.

President Obama created a Task Force and established a full-time presence in the White House to ensure that the Nation would be ready for when another pathogen threatened the American people.

COVID–19 AND PUBLIC HEALTH

Today, COVID–19 is a new coronavirus threatens the world.

As of March 11, 2020, the global death toll is 4,382, while more than 121,622 people have been infected in more than 80 countries.

In China, the COVID–19 outbreak has infected around 90,000 individuals, and killed 3,158 people.

More than 60,000 people in China have recovered from COVID–19.

Until China lifts the draconian quarantine measures put into place, we will not know if they are past the worst consequences of COVID–19.

The number of deaths will surely rise in the coming weeks, but we must not lose heart and be delayed in placing every tool needed in the hands of physicians, researchers, medical professionals, public health agencies, and Federal, State, and local emergency response agencies to defeat COVID–19.

COVID–19 IN THE UNITED STATES

On Tuesday, March 11, Johns Hopkins reported that COVID–19 cases in the United States have surpassed 1,000.

The Centers for Disease Control and Prevention (CDC) reported COVID–19 is in 35 States.

Texas reported at least 8 new cases of Coronavirus in the State on Tuesday.

They include the first known instances in Dallas, Gregg, Montgomery, and Tarrant counties, while 2 new Collin County patients, including a 3-year-old, contracted the virus from a family member.

There was also a new, seventh case in Montgomery County, which is outside of Harris County late Tuesday.

In Dallas County, 2 people tested positive.

The first was a "77-year-old out-of-State traveler with an extensive travel history," according to a news release.

The second was a person in their 50's who "is a close contact" of the 77-year-old. County officials said they expected the second person's coronavirus test to come back positive, but that "there is not a cause for concern."

This virus is a serious public health threat, but this does not mean that we should have a public health panic.

FIGHTING THE SPREAD OF COVID–19

The weapons for slowing the spread of COVID–19 are simple and they work:

- Washing hands;
- Sanitizing surfaces; and
- Quarantines.

These tools for controlling the spread of infectious diseases are as old as civilization and are still used today because they work.

Some of the first records of the use of cleaning, washing, and isolation of the sick is found in the Bible in the Book of Leviticus Chapter 13.

Which provides detailed instructions to the community about leprosy, a dreaded contagious disease.

The isolation or quarantine for leprosy was 14 days, the same period that COVID quarantines may last.

Given the fluid nature of the events unfolding the time may be longer based upon circumstances.

I believe that we are not doing enough to prepare the public for what may be localized, household, or individual quarantines to address spread of COVID–19.

My concerns about public education are informed by my work to address the Zika Virus, a mosquito-borne illness, which emerged as a domestic public health threat in Gulf Coast States in 2016.

ZIKA VIRUS

Zika Virus was the first illness known to cause severe brain deformities in a developing fetus while in the womb.

I worked with infectious disease experts, policy makers, and worked to raise awareness with my fellow Members of Congress.

Congresswoman Rosa DeLauro and I published an editorial in the *Houston Chronical* on the importance of the Federal response to the Zika Virus to help focus Congressional attention on the issue.

This year, when I saw news reports in early January on the novel Coronavirus's rapid spread and the numbers of infected expanding so quickly, I knew this was not something to be taken lightly and that time was not on our side to mount an effective defense.

EFFORTS TO RAISE COMMUNITY AWARENESS ABOUT COVID–19

On February 10, 2020, I held the first press conference on the issue of the novel Coronavirus at Houston Intercontinental Airport.

I was joined by public health officials, local unions, and advocates to raise awareness regarding the virus and the implications it might have for travel to the United States from China and to combat early signs of discrimination targeting Asian businesses in the United States.

On February 24, 2020, I held a second press conference on the International Health Regulations Emergency Committee of the World Health Organization declaration of a "public health emergency from the outbreak of the Coronavirus."

At this media conference, I also released an Action Plan:

- ENHANCED PRODUCTION OF N–95 MASKS
- INFORMING STATE HEALTH AGENCIES AND ALL FEDERALLY-QUALIFIED HEALTH CLINICS TO TEST ALL PATIENTS PRESENTING WITH FLU-LIKE SYMPTOMS FOR THE CORONAVIRUS
- INCREASE THE SUPPLY OF FLU VACCINE AND USE PUBLIC SERVICE ANNOUCEMENTS TO PROMOTE GETTING A FLU SHOT TO REDUCE THE NUMBER OF PERSONS WITH FLU-LIKE SYMPTOMS
- TASK FORCE MUST NAME A SINGLE CORONAVIRUS AUTHORITATIVE SOURCE FOR ALL FEDERAL INFORMATION ON THE VIRUS AND ESTABLISH CLEAR COMMUNICATION LINKS TO K–12 AND POST-SECONDARY SCHOOLS, THE MEDIA, AND THE PUBLIC
- ESTABLISH A REQUIREMENT THAT THE NATION'S AIRPORTS, TRAINS, AND MASS TRANSIT SYSTEMS, BOTH SMALL AND LARGE, NEED TO HAVE RESPONSE TEAMS AS NECESSARY TO DEAL WITH AND TREAT THE TRAVELING PUBLIC
- MAKE SURE THE FEDERAL ADVISORY TASK FORCE MAKES PUBLIC REPORTS ON THE STATUS OF THE SPREAD OF THE CORONAVIRUS INCLUDING THROUGH THE DEVELOPMENT OF AN APP THAT PROVIDES UP-TO-DATE TRAVEL ADVISORIES REGARDING CERTAIN COUNTRIES AND BASIC INFORMATION ON THE VIRUS.

On February 26, 2020, I sent a letter to the Chair and Ranking Member of the Committee on Homeland Security, seeking a meeting with Acting Secretary of Homeland Security Chad Wolf to gain insight into the preparedness of the agency to address a possible pandemic.

On February 28, 2020, I spoke on the floor of the House and announced plans to form a Congressional Coronavirus Task Force.

On March 4, 2020, the House of Representatives is giving a full-throated response to Coronavirus by introducing $8.3 billion in funding to help State and local public health departments meet the challenge of preparing communities for COVID–19.

On Monday, March 9, 2020, we sent the Dear Colleague invitation to other Members of the House to signed by me, Congressmen Brian Fitzpatrick, and Dr. Raul Ruiz, to join the Congressional Coronavirus Task Force.

Our Nation can win this battle against COVID–19 because we have knowledgeable and trained virologists, public health experts, and physicians who are available to help people get the information they need and provide care should they need it.

To win we must have the leadership, appropriate levels of funding, and the guidance of State, Tribal, territorial, and local public health officials.

I look forward to witness testimony on this important homeland security threat.

Thank you.

Ms. UNDERWOOD. I welcome our witnesses. Mr. Ken Cuccinelli currently serves as the senior official performing the duties of the deputy secretary for the Department of Homeland Security.

He is also the Department of Homeland Security's representative to the White House Coronavirus Task Force. Previously, he served as acting director of U.S. Citizenship and Immigration Services. Mr. Cuccinelli was attorney general in Virginia from 2010 to 2014.

Next, we have Doctor Stephen Redd, who is the deputy director for public health service and implementation science at the Centers for Disease Control and Prevention.

He previously directed CDC's Office of Health Preparedness and Response where he was responsible for State and local readiness and emergency operations. Doctor Redd is a medical doctor, an epidemiologist with 30 years of experience at CDC.

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

I now ask each witness to summarize their statement for 5 minutes beginning with Mr. Cuccinelli.

STATEMENT OF KEN CUCCINELLI, II, SENIOR OFFICIAL PERFORMING THE DUTIES OF THE DEPUTY SECRETARY, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. CUCCINELLI. Thank you, Vice Chairman Underwood, Chairman Thompson, Ranking Member Rogers, and distinguished Members of the committee. It is my honor to appear before you today to testify about the work of the Department of Homeland Security, what we are doing to respond to the current outbreak of the coronavirus.

I am very proud of the work the men and women of DHS and our partners at the Department of Health and Human Services and across the Government are doing. The Department's top priority is the safety and security of the American people.

DHS is taking action at airports and land ports of entry to support HHS in slowing the spread of the novel coronavirus to say nothing of our maritime work.

DHS continues to work very closely with our partners at CDC throughout all admissible persons who have been in mainland China and Iran in the previous 14 days to one of 11 designated airports of entry where the Federal Government has focused public health resources.

At all ports of entry, CBP officers continue to remain alert and notify CDC and other public health officials when encountering passengers exhibiting signs of overt illness, regardless of their travel history.

DHSCWMD is currently supporting CDC's enhanced entry screening efforts through agreements with State, local, or private-sector emergency medical services, public health, and first responder personnel at all 11 designated airports of entry for passengers who have been in China or Iran within the previous 14 days.

CWMD supports the collection of passenger information for CDC to provide direct information to State and local public health officials to facilitate contact tracing efforts. CBP and the Coast Guard continue their work to recognize, detect, and assist individuals arriving through our land ports and waterways.

In coordination with CDC and U.S. Coast Guard, CBP has measures already in place at all ports of entry to identify travelers with

overt signs of illness to minimize the risk to the public. U.S. Coast Guard reviews all advanced notice of arrivals 96 hours in advance of a schedules arrival of a ship in port.

The Coast Guard captain of the port communicates any concerns stemming from sick or deceased crew or passengers to their Coast Guard chain of command and the cognizant CDC quarantine station who will coordinate with local health authorities. This process has been working smoothly across the country.

At and between land ports of entry, CBP is identifying persons with recent travel to China or Iran and making appropriate referrals to CDC or the local health system.

The DHS work force is our greatest asset, and every precaution is being taken to keep our work force safe, especially for our officers and agents on the front lines. Ensuring that these individuals and all DHS personnel remain safe and healthy is a critical—and immediately upon the onset of COVID–19 as a global concern, the Department proactively took action.

The DHS management directorate has established a work force protection command center to ensure that protective procedures are in place for the front-line work forces who may regularly encounter potential disease carriers and is working with all DHS components to assess their readiness.

CWMD continues to work with the U.S. Government interagency, State Governors, State and local public health agencies, non-governmental organizations, the Governments of Mexico and Canada, and private industry partners and stakeholders on medical and public health coordination and information sharing.

The Cybersecurity and Infrastructure Security Agency, CISA, has been assessing the National critical functions for potential impacts to infrastructure and systems from COVID–19 and is working closely with private-sector owners and operators to identify issues of concern and ensure continuity of these critical assets.

FEMA is providing support to HHS as the lead Federal agency in the areas of incident management, resource planning, and Federal interagency coordination. Additionally, FEMA remains postured to support HHS with consequence management to anticipate any mitigation actions.

The American public can be assured that DHS and its component agencies are taking decisive action to analyze a threat, minimize risk, and slow the spread of the virus by working closely with CDC health professionals and interagency partners involved in this whole-of-Government effort.

I want to thank you, Vice Chairwoman Underwood, Ranking Member Rogers, Chairman Thompson, and the Members and staff of this committee for the support you have shown the Department and the Government's effort to respond to COVID–19. I look forward to your questions.

[The prepared statement of Mr. Cuccinelli follows:]

PREPARED STATEMENT OF KEN CUCCINELLI, II

MARCH 11, 2020

INTRODUCTION

Chairman Thompson, Ranking Member Rogers, and distinguished Members of the committee. It is my honor to appear before you today along with my CDC colleague RADM Redd to testify about the work the Department of Homeland Security (DHS) is doing to respond to the current outbreak of Coronavirus Disease 19, known as COVID–19.

Let me first say that I am very proud of the work that the men and women of DHS and our partners at the Department of Health and Human Services (HHS) and across the Government are doing to contain the spread of the disease, slow the spread of the disease, and to prepare and provide for a domestic response. The Department's top priority is the safety and security of the American people, and we are committed to an aggressive, proactive, and preemptive whole-of-Government response in fulfillment of our mission. As required by Congress, in 2018, President Trump signed the first-ever "National Biodefense Strategy" to build upon our ability to rapidly respond to and limit the impacts of bioincidents like the one we are facing now. We are seeing that strategy pay dividends as we implement a whole-of-Government response to this disease.

Additionally, the operational coordination and cooperation between HHS and DHS dates back to a 2005 Memorandum of Understanding (MOU) enhancing preparedness against the introduction, transmission, and spread of quarantinable and serious communicable disease into the United States. Our combined experience and long-standing relationship, continues to be beneficial today. Across the air, land, and maritime domains, DHS has taken and continues to take proactive measures to address COVID–19.

PROTECTING AMERICANS THROUGH OUR EFFORTS AT AIR PORTS OF ENTRY

DHS is taking action at airports of entry to support HHS in slowing the spread of the novel coronavirus. DHS is working to decrease the workload of public health officials, expedite the processing of U.S. citizens returning from China, and, above all, ensure that resources are focused on the health and safety of the American people.

On January 31, 2020, the Secretary of Health and Human Services declared COVID–19 a public health emergency in the United States, and the President signed a Presidential Proclamation using his authority pursuant to Section 212(f) of the Immigration and Nationality Act to suspend the entry into the United States of foreign nationals who pose a risk of transmitting the virus. As of 5 p.m. Eastern Standard Time on February 2, 2020, foreign nationals, other than immediate family of U.S. citizens and lawful permanent residents and other individuals falling within narrow exceptions to the Proclamation, who were physically present in the People's Republic of China, excluding Hong Kong and Macau, within the previous 14 days has been denied entry into the United States. On February 29, 2020, President Trump expanded this Proclamation to also include most foreign nationals who have been in Iran within the previous 14 days.

DHS, including U.S. Customs and Border Protection (CBP) and the Transportation Security Administration (TSA), continues to work very closely with our partners at the Centers for Disease Control and Prevention (CDC) to route all admissible persons who have been in mainland China and Iran in the previous 14 days to one of 11 designated airports of entry where the Federal Government has focused public health resources.

Any admissible person who has been in Hubei province, China in the previous 14 days is subject to up to 14 days of mandatory quarantine where CDC has made arrangement with State and local authorities to ensure they are provided proper medical care and health screening. Any admissible person who has been in the rest of mainland China or Iran within the previous 14 days undergoes proactive entry health screening at one of these airports and, if they are asymptomatic, up to 14 days of self-monitoring to ensure they have not contracted the virus and do not pose a public health risk.

DHS continues to closely monitor the spread of the virus and is taking actions to ensure an appropriate response. We are working very closely with airlines and our partners in South Korea and Italy to implement exit screening procedures in those locations for travelers coming to the United States.

DHS continues to facilitate enhanced health screening of travelers entering the United States who have recently been in China or Iran. Travelers identified by CBP

officers during their primary inspection are referred to a secondary screening area, where contractor personnel (through agreements by the DHS Countering Weapons of Mass Destruction Office (CWMD)) conduct enhanced entry screening. Travelers who have been in Hubei province, China within the previous 14 days or who exhibit symptoms consistent with COVID–19 are sent to CDC for tertiary screening and consideration for quarantine. Between February 2 and March 8, CBP referred 56,543 travelers for secondary screening by the CWMD contract personnel at the 11 funneling airports. Of these, 91 individuals required referral to the CDC for medical evaluation. At all ports of entry, CBP officers continue to remain alert and notify CDC and other public health officials when encountering passengers exhibiting signs of overt illness, regardless of their travel history.

We realize these actions could prolong travel times for some individuals; however public health and security experts agree these measures are necessary to contain the spread of the virus and protect the American people. To minimize disruptions, CBP and the air carriers are working to identify qualifying passengers before their scheduled flights.

DHS CWMD is currently supporting CDC's enhanced entry screening efforts through agreements with State, local, or private-sector Emergency Medical Services, public health, and first responder personnel at all 11 designated airports of entry for passengers who have been in China or Iran within the previous 14 days. CWMD established this capability in response to the Ebola virus threat that was emerging in the Democratic Republic of the Congo last summer. These actions ensured a trained, vetted, and badged workforce was ready to rapidly deploy to support the CDC with airport screening operations. DHS was able to adapt this capability to quickly address the threat of COVID–19 and support CDC's enhanced health screenings in the National interest.

CWMD support includes the collection of passenger information allowing CDC to provide direct information to State and local public health officials to facilitate contact tracing efforts. CWMD's efforts have significantly increased the accuracy of the data collected.

PROTECTING AMERICANS THROUGH OUR EFFORTS AT LAND AND SEA PORTS OF ENTRY

CBP and the United States Coast Guard (USCG) continue their work to recognize, detect, and assist individuals arriving in the United States through our land ports and waterways who may be carrying the virus. In coordination with the CDC and USCG, CBP has measures already in place at all ports of entry to identify travelers with overt signs of illness who may be potentially infected with a communicable disease and to minimize the risk to the traveling public.

USCG continues to review all "Advance Notice of Arrivals" 96 hours in advance of the scheduled arrival of a ship in port in accordance with its current policies. The Captain of the Port will communicate any concerns stemming from sick or deceased crew or passengers to their Coast Guard chain of command and the cognizant CDC quarantine station, who will coordinate with local health authorities. This process has been working smoothly across the country.

To ensure continued facilitation of international trade, non-passenger commercial vessels that have been to China (excluding Hong Kong and Macau) or Iran or embarked crewmembers who have been in China (excluding Hong Kong and Macau) or Iran within the previous 14 days, with no sick crewmembers, may be permitted to enter the United States and conduct normal operations, with restrictions. Crewmembers on these vessels will be required under Captain of the Port authority to remain aboard the vessel except to conduct specific activities directly related to vessel cargo or provisioning operations.

At and between land ports of entry, CBP is identifying persons with recent (within 14 days) travel to China or Iran and making appropriate referrals to CDC or the local health system.

MONITORING THE DISEASE

DHS and its components were well-prepared to take proactive and preemptive action to mitigate the threat, minimize risk, and slow the spread of the virus by working closely with CDC and other interagency partners as cases of the virus in China began to increase. The National Biosurveillance Integration Center (NBIC) within DHS CWMD began tracking an outbreak of unidentified viral pneumonia in Wuhan, China on January 2, providing early situational awareness on what we now know is COVID–19. NBIC continues to generate and distribute daily updates to thousands of Federal, State, and local partners to apprise them of the situation. NBIC further supports CDC and CBP operations by analyzing passenger travel data relevant to the movement of persons out of the impacted area. These interagency analyses of

flight data, in conjunction with operational considerations, helped inform the selection of U.S. airports for enhanced health screening for coronavirus.

The Science & Technology Directorate's (S&T) National Biodefense Analysis and Countermeasures Center has received an isolate of the virus and is collaborating with CWMD to produce data on environmental stability of the virus as well as decontamination strategies to inform DHS component and interagency operations. Building on experience gained during the response to the previous Ebola outbreak, S&T has also developed and maintains a SARS–CoV–2 Master Question List (MQL), which tracks current knowledge and research efforts on the virus across the Government and academia, providing situational awareness on these important efforts.

DHS WORKFORCE PROTECTION

The DHS workforce is our greatest asset, and every precaution is being taken to keep our workforce safe, especially for our USCG, TSA, CBP, and U.S. Immigration and Customs Enforcement officers and agents on the front lines. Ensuring that these individuals, and all DHS personnel remains safe and healthy is critical, and immediately upon the on-set of COVID–19 as a global concern, the Department proactively took action.

The DHS Management Directorate has established a workforce protection command center to ensure that protective procedures are in place for the front-line workforces who may regularly encounter potential disease carriers and is working with all DHS components to assess their readiness. Some current precautionary measures for these officers include providing gloves, masks, and hand sanitizer.

Although the most recent CDC guidance does not recommend changes to routine security screening operations or respiratory protection, TSA is authorizing front-line personnel, whose security screening tasks require routine, close contact with the traveling public, to wear surgical masks if they choose to do so. CBP personnel have access to personal protective equipment (PPE) as part of their normal operations at all ports of entry and have been provided guidance in case of exposure to a contagion. CBP issued an updated Job Hazard Analysis on February 5, 2020, to all employees that outlines the current comprehensive PPE guidance, which includes guidance about wearing masks under the appropriate circumstances.

DHS continues to share information with the workforce on an on-going basis. Our workforce protection command center is in close coordination with Federal health partners and component health and safety officials. Furthermore, the chief medical officer (CMO) in DHS CWMD continues to advise DHS leadership on the on-going health threat and its impact on workforce health.

SUPPORTING THE INTERAGENCY

As the lead Federal agency for coronavirus response, HHS leads outreach to State, local, Tribal, and territorial public health and safety officials on the outbreak status and the U.S. public health response. In support of HHS, DHS provides information to ports of entry on the risks of COVID–19, advising that front-line personnel be alert for individuals who may have come from an infected region. TSA has been working with select airlines to notify travelers on the risks of potentially contracting the communicable disease. CBP has posted travel notices at land border crossings informing passengers about the virus. Finally, the USCG has issued a Marine Safety Information Bulletin to maritime industry partners advising of required reporting of illnesses or deaths on-board arriving commercial vessels and delineating conditions whereby vessels may be denied entry into the United States.

CWMD, which includes the DHS CMO, continues to work with the USG interagency, State/local public health agencies, non-governmental organizations, the Governments of Mexico and Canada, and private industry partners/stakeholders on medical and public health coordination and information sharing.

Additionally, the Cybersecurity and Infrastructure Security Agency (CISA) has been assessing the National Critical Functions for potential impacts to infrastructure and systems from COVID–19 and is working closely with private-sector owners and operators to identify issues of concern and ensure continuity of these critical assets in the event that COVID–19 reaches pandemic levels and the United States sees significant community spread.

Since February 12, DHS has been augmenting the HHS Secretary's Operations Center with personnel from FEMA, DHS HQ, USCG, CWMD, and CISA, who are assisting the HHS-led interagency response through increased support and coordination.

FEMA is providing support to HHS as the lead Federal agency in the areas of incident management, resource planning, and Federal interagency coordination. Additionally, FEMA remains postured to support HHS with consequence management

to anticipate any potentially necessary mitigation actions. This on-going planning effort is similar to the experience with past outbreaks of Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS), caused by similar viruses.

CONCLUSION

The American public can be assured that DHS and its component agencies are taking decisive action to analyze the threat, minimize risk, and slow the spread of the virus by working closely with CDC health professionals and interagency partners involved in this whole-of-Government effort.

I want to thank you, Chairman Thompson, Ranking Member Rogers, and the Members and staff of this committee for the support you have shown the Department and the Government's effort to respond to COVID–19.

I look forward to your questions.

Ms. UNDERWOOD. Thank you for your testimony.

I now recognize Doctor Redd to summarize his statement for 5 minutes.

STATEMENT OF STEPHEN C. REDD, DEPUTY DIRECTOR OF PUBLIC HEALTH SERVICE AND IMPLEMENTATION SCIENCE, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. REDD. Good afternoon, Chairs Underwood and Thompson, Ranking Member Rogers, and Members of the committee. Thank you for the opportunity to talk with you about CDC.

Ms. UNDERWOOD. Turn on your mic, sir.

Dr. REDD. Is the mic not on. Maybe I need——

Ms. UNDERWOOD. OK.

Mr. REDD [continuing]. To get closer.

Ms. UNDERWOOD. Thank you.

Dr. REDD. Start over. Good afternoon, Chairwoman Underwood and Chair—I am sorry—Chairs Underwood and Thompson, Ranking Member Rogers, and Members of the committee. Thank you for the opportunity to talk with you about CDC's role in the response to the novel 2019 coronavirus or COVID–19.

Before I begin, it is important to recognize that this is a new virus and a new disease. The science continues to accumulate. We will continue to incorporate that new science into our response decisions and response posture.

There are three overriding themes that have guided our response. First, CDC's role in this interagency response is built on decades of infectious disease experience and planning for pandemic flu and other health emergencies. Second, our response is dependent on support of a network of dedicated front-line public health workers in our communities, the State and local health departments.

Third, as we begin to see community spread of this virus, it will be important for all of us to take action in preventing its spread through common sense public health precautions like handwashing, staying home if you are sick, and particularly for high-risk and vulnerable populations avoiding crowds, especially in poorly-ventilated spaces.

I encourage you to visit CDC's coronavirus website to learn more about what you can do. Thank you for the second time we have been able to talk about the website and all the information that is there.

From the outset, CDC and our U.S. Government partners have implemented an aggressive multi-layered strategy to slow the introduction of this virus into the United States to buy time so that our scientist could learn how this virus behaves, to prepare our Nation's public health system and health care system for the possibility of a global pandemic, which as you have heard has been declared today, and to educate Americans how best to prepare for disruptions to our daily lives and risk to our families.

The administration's interagency containment strategy has relied upon tried and true public health interventions. Early diagnosis, isolation, and contact tracing, travel advisories, and targeted travel restrictions, selective use of quarantine for individuals returning from global transmission hot zones.

Without immunity or treatment, our Nation's public health response has relied upon detection and contact tracing to slow the emergence of this virus into the United States.

February 25 was an inflection point for the outbreak when for the first time we saw new cases outside of China outpace new cases within China. We have observed rapid, wide-spread person-to-person transmission in South Korea, Iran, and Italy. Before long we had detected our first case of community spread in California.

So what have we learned? The virus spreads easily and rapidly mostly through respiratory droplets from sneezing and coughing. Going from 30 cases detected by Chinese scientists to over 100,000 cases worldwide in a little less than 2 months.

Reports from China based on more than 70,000 cases of COVID–19 indicate that about 80 percent of patients had mild illness and recovered. Fifteen to 20 percent developed serious illness, predominately in older persons and persons with chronic underlying medical conditions.

For this reason, CDC has issued new guidance advising seniors to avoid crowds, stay closer to home, and avoid cruise ship travel and long plane trips.

As of today, CDC has received confirmation of more than 900 cases of COVID–19 in 38 States plus New York City and the District of Columbia. It is with great sadness that I report that there have been 31 deaths from this disease in the United States.

As we experience growing community spread in the United States, State and local health agencies on the front lines will be making difficult decisions to reduce the spread with CDC guidance and support. Thank you for your support for additional resources to increase public health capacity on our communities.

CDC has put more than 630 staff in the field and has—is working side-by-side with other Federal partners—State and local partners—and we have had over 1,500 people working on the response within Atlanta and the field. CDC is committed to this mission. We will continue to work 24/7 to protect the American people from this global health threat.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Redd follows:]

PREPARED STATEMENT OF STEPHEN C. REDD

Since President Trump took office, his work to protect the health and safety of the American people has included a specific focus on monitoring, preparing for, and responding to biological threats, such as infectious disease outbreaks. As soon as the

United States became aware of a novel coronavirus at the end of 2019, the U.S. Government was tracking its spread and began preparing necessary responses.

Within the first 2 weeks of China's initial report of the outbreak in December 2019, China reported 45 pneumonia cases and 2 deaths. More recently, there has been an increase in cases outside of China.

COVID–19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans. This new disease, officially named Coronavirus Disease 2019 (COVID–19) by the World Health Organization (WHO), is caused by the SARS–COV–2 virus, which is in the same family of viruses as that cause the common cold. There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. Coronaviruses are a large family of viruses. Some cause illness in people, and others, such as canine and feline coronaviruses, only infect animals. Rarely, animal coronaviruses that infect animals have emerged to infect people and can spread between people. This is suspected to have occurred for the virus that causes COVID–19. Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) are two other examples of coronaviruses that originated from animals and then spread to people. The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low. The greater risk is for people who have recently traveled to an affected country or been exposed to someone with COVID–19.

On January 29, 2020, President Trump announced the formation of the President's Task Force on the Novel Coronavirus, which is chaired by the Secretary for Health and Human Services and coordinated through the National Security Council. The President's Task Force is composed of subject-matter experts from the White House and several U.S. Government agencies, and it includes some of the Nation's foremost experts on infectious diseases. The Task Force is leading the administration's efforts to monitor, contain, and mitigate the spread of COVID–19 while ensuring that the American people have the most accurate and up-to-date information to protect themselves and their families.

The President's top priority is the health and welfare of the American people, and his administration has made it a priority to prepare for infectious disease outbreaks that can cross borders. In 2018, President Trump launched the National Biodefense Strategy, which lays out a framework for coordination among agencies, with the Secretary of the U.S. Department of Health and Human Services (HHS) as chair of the Biodefense Steering Committee, and helps identify gaps in preparedness and response. As the situation around the new coronavirus evolves, the administration will continue its coordinated response, in collaboration with State and local governments and the private sector, and adjust its positioning as needed.

Within HHS, the Centers for Disease Control and Prevention (CDC), the Assistant Secretary for Preparedness and Response (ASPR), the National Institute of Allergy and Infectious Diseases (NIAID), and the Food and Drug Administration (FDA) play critical roles in responding to COVID–19 by preventing and slowing the spread of the disease, assisting repatriated Americans, protecting the supply of food, drugs, and devices, and developing diagnostics, therapeutics, and vaccines.

CENTERS FOR DISEASE CONTROL AND PREVENTION

In late December 2019, Chinese authorities announced a cluster of pneumonia cases of unknown etiology centered on a local seafood market in Wuhan, China, with an estimated case onset in early December. CDC immediately began monitoring the outbreak, and within days—by January 7, 2020—had established a Center-led Incident Management Structure. On January 21, 2020, CDC transitioned to an agency-wide response based out of its Emergency Operations Center. This allows CDC to provide increased operational support to meet the outbreak's evolving challenges and provides strengthened functional continuity to meet the long-term commitment needed to curb the outbreak.

CDC is assisting ministries of health in countries in every region of the globe with their most urgent and immediate needs to prevent, detect, and respond to the COVID–19 outbreak.

CDC's most expert and practiced infectious disease and public health experts are dedicated to this response 24/7 to protect the American people. CDC is a disease preparedness and response agency, and this work is fundamental to our mission both domestically and internationally. The agency's approach to COVID–19 is built upon decades of experience with prior infectious disease emergencies including responses to SARS, MERS, and Ebola, and to pandemic influenza.

To mitigate the impact of COVID–19 within the United States, CDC is working alongside Federal, State, local, Tribal, and territorial partners, as well as public

health partners. This public health response is multi-layered and includes aggressive containment and mitigation activities with an objective to detect and minimize introductions of this virus in the United States so as to reduce its spread and impact. It is impossible to catch every single traveler returning from an affected country with this virus—given the nature of this virus and how it's spreading. Our goal continues to be slowing the introduction of the virus into the United States as we work to prepare our communities for more cases and possible sustained spread.

To accomplish this, CDC is also working with multiple countries, in collaboration with U.S. Agency for International Development (USAID) and other Federal agencies and WHO to support ministries of health around the globe to prepare and respond to the outbreak. For example, the U.S. Government is helping to support countries to implement recommendations provided by WHO related to the identification of people who might have this new infection, diagnosis, and care of patients, and tracking of the outbreak. CDC staff are also starting to work together with interagency colleagues in those countries to conduct investigations that will help inform response efforts going forward.

The agency is using its existing epidemiologic, laboratory, and clinical expertise to gain a more comprehensive understanding of COVID–19. CDC is leveraging prior programmatic investments in domestic and global public health capacity and preparedness to strengthen the agency's response to COVID–19. Thus far, this response has been built largely on the foundation of our seasonal and pandemic influenza program's infrastructure. The on-going response to COVID–19 also demonstrates CDC's continued commitment to strengthen global health security. CDC has been engaged in global health security work for over 7 decades. Thanks to investments in Global Health Security, the U.S. Government's work has helped partner countries build and improve their public health system capacity. This global effort strengthens the world's ability to prevent, detect, and respond to infectious diseases like this new coronavirus.

This outbreak also underscores the need for the United States to continue to play a leadership role on the global stage, and to strengthen global capacity to stop disease threats at their sources, before they spread. Furthermore, the outbreak demonstrates the importance of continued investment in our Nation's public health infrastructure. Despite years of progress in domestic disease prevention and response, efforts to help modernize our Federal, State, and local capability and health systems that are crucial to responding to and understanding unprecedented threats continue.

The U.S. Government has taken unprecedented steps to prevent the spread of this virus and to protect the American people and the global community from this new threat and allow State, local, territorial, and private partners time to prepare for any necessary response and mitigation activities. Since February 2, 2020, pursuant to arrival restrictions imposed by the Department of Homeland Security, flights carrying persons who have recently traveled from or were otherwise present within mainland China or other affected countries have been funneled to designated U.S. airports with CDC quarantine stations. At these airports, passengers are subject to enhanced illness screening and self-monitoring with public health supervision up to 14 days from the time the passenger departs the affected country. This enhanced entry screening serves 2 critical purposes. The first is to detect illness and rapidly respond to symptomatic people entering the country. The second purpose is to educate travelers about the virus and what to do if they develop symptoms.

These measures are part of a layered approach which includes our other core public health efforts, including aggressively tracking COVID–19 around the globe, building laboratory capacity, and preparing the National health care system for community spread. These core capabilities and expertise are essential to CDC's comprehensive approach to addressing this outbreak.

While CDC believes that the immediate risk of this new virus to the American public is low, CDC is preparing the Nation's health care system to respond to identification of individual cases and potential person-to-person transmission of COVID–19 in the community, at the same time ensuring the safety of its patients and workers. CDC has developed guidance on appropriate care and infection control for patients with COVID–19 and is engaging regularly with clinical and hospital associations to confirm that its guidance is helpful and responsive to the needs of the health care system.

Furthermore, understanding the current constraints of the global supply of personal protective equipment (PPE), CDC is working with industry and the U.S. health system to comprehend possible effects on facilities' abilities to procure the needed levels of PPE, and to provide strategies to optimize the supply of PPE.

Effective disease surveillance enables countries to quickly detect outbreaks and continuously monitor for new and reemerging health threats. CDC continues to monitor the COVID–19 situation around the world.

CDC has begun working with domestic public health laboratories that conduct community-based influenza-like illness surveillance and leveraging our existing influenza and viral respiratory surveillance systems so that we may begin testing people with flu-like symptoms for the SARS–COV–2 virus. HHS is developing plans to expand this effort.

This collaboration with domestic public health labs is another layer of our response that will help us detect if this virus is spreading in a community. All of our efforts now are to prevent the sustained spread of this virus in our communities, but we need to be prepared for the possibility that it will spread. Results from this surveillance could necessitate changing our response strategy.

CDC has issued guidance for people at high risk of exposure to the virus, including flight crews, recent travelers to China, and health care workers. Through its extensive Health Alert Network, CDC shared guidance for clinical care for health care professionals and State and local health departments. Health departments, in consultation with health care providers, can evaluate patients and determine whether someone may have the illness and should be subjected to additional diagnostic testing.

CDC has a demonstrated record of innovative science- and evidence-based decision making, and an experienced and expert workforce that is working 24/7 to combat this public health emergency. The COVID–19 outbreak is evolving rapidly, and the U.S. Government is constantly making adjustments to respond to the changing nature of this public health emergency. Our goal continues to be slowing the introduction of the virus into the United States and preparing our communities for more cases and possible sustained spread. While leaning forward aggressively with the hope that we will be able to prevent community spread, CDC remains vigilant in confronting the challenges presented by this new coronavirus.

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Currently, there are no vaccines or therapeutics approved by the FDA to treat or prevent novel coronavirus infections. The Biomedical Advanced Research and Development Authority (BARDA), part of ASPR, is working with counterparts across the Government, including within HHS and with the Department of Defense (DOD). The team is reviewing potential vaccines, treatments, and diagnostics from across the public and private sectors to identify promising candidates that could be developed to detect, protect against, or treat people with coronavirus infections. BARDA is working closely across the U.S. Government to assess and identify potential partners and technologies suitable to address the COVID–19 outbreak—both for prevention and treatment.

This has allowed BARDA to leverage existing partnerships, accelerating the development of COVID–19 medical countermeasures, including diagnostics, therapeutics, and vaccines. Established partners, including Regeneron, Janssen, and Sanofi Pasteur, have shown success in developing both prophylactic and therapeutic medical countermeasures for emerging infectious diseases.

BARDA is collaborating with Regeneron to leverage their partnership agreement to develop multiple monoclonal antibodies that, individually or in combination, could be used to treat this emerging coronavirus. Regeneron's monoclonal antibody discovery platform, called VelocImmune, was used to develop a promising investigational three-antibody therapeutic which was deployed to treat Ebola in the most recent outbreak in the Democratic Republic of the Congo, and an investigational two-antibody therapeutic to treat MERS. The technology shortened multiple aspects of the product development time line for therapeutics to treat MERS and Ebola from years to months. The technology helped shorten certain stages of drug development, including the process of antibody discovery and selection, preclinical-scale manufacturing, and clinical-scale manufacturing. BARDA and Regeneron are working to utilize these monoclonal antibodies, produced by a single clone of cells or a cell line with identical antibody molecules, which will bind to certain proteins of a virus, reducing the ability of the COVID–19 virus to infect human cells.

BARDA is working with Janssen to leverage their Ebola, Zika, HIV vaccine platform to expedite development of vaccines that protect against the SARS–CoV–2 virus. Using existing resources, BARDA will share research and development costs and expertise with Janssen to help accelerate Janssen's investigational COVID–19 vaccine into clinical evaluation. Janssen will also scale-up production and manufacturing capacities required to manufacture the candidate vaccine. This same approach was used to develop and manufacture Janssen's investigational Ebola vaccine with BARDA support; that vaccine is being used in the Democratic Republic of the Congo as part of the current Ebola outbreak response. Additionally, BARDA and Janssen are working together to help develop treatments for coronavirus infec-

tions. Janssen will conduct high throughput screening on thousands of potential antiviral compounds in order to identify medicines that could safely and effectively be used to reduce the severity of illness and treat COVID–19 infections, as well as identify compounds that have antiviral activity against SARS–CoV–2 as an initial step in developing new treatments. These products include those in development to treat and prevent MERS or SARS, which are caused by coronaviruses also related to COVID–19.

Finally, in their work with Sanofi Pasteur, BARDA is able to leverage a licensed recombinant influenza vaccine platform to produce a recombinant SARS–CoV–2 vaccine candidate. The technology produces an exact genetic match to proteins of the virus. DNA encoding the protein will be combined with DNA from a virus harmless to humans, and used to rapidly produce large quantities of antigen which stimulate the immune system to protect against the virus. The antigens will be separated and collected from these cells and purified to create working stocks of vaccine for advanced development.

BARDA has initiated early steps of medical countermeasures development with partners and will continue to work to accelerate this process. Availability of these medical countermeasures is essential to save lives and protect Americans against 21st Century public health threats.

Our Nation's health care system is better prepared than it has ever been. For example, all 50 States have Pandemic Plans, as a requirement of CDC's Public Health Emergency Preparedness Program (PHEP) and ASPR's Hospital Preparedness Program (HPP). HPP was established after the September 11, 2001, terrorist attacks, with the goal of improving the capacity of local hospitals across the country to deal with disasters and a large influx of patients in an emergency. Using HPP funding, State grantees initially purchased equipment and supplies needed for emergency medical surge capacity. Over time, the program has successfully evolved to support local, coordinated health care coalitions, including hospitals, public health facilities, emergency management agencies, and emergency medical services providers. Investments administered through PHEP and HPP have improved individual health care entities' preparedness and have built a system for coordinated health care system readiness. HPP is the only source of Federal funding to prepare the Nation's mostly private health care system to respond to emergencies, including COVID–19.

Beginning in 2018, ASPR has been supporting Regional Disaster Health Response Systems (RDHRS) pilot projects. The RDHRS concept aims to provide funding directly to hospitals and health care systems to establish multi-State regional partnerships to increase preparedness and response capability and capacity for hospitals and health care facilities in advance of, during, or immediately following incidents, including emerging infectious diseases. Two sites were selected in September 2018 to begin development of RDHRS pilots. In 2019, two grants were awarded to support new centers of excellence pilots focused on pediatric disaster care. The RDHRS and Pediatric Disaster Care Center of Excellence cooperative agreement requirements are intentionally aligned to ensure synergy between the programs and collaboration between all sites and facilities. Ultimately, these efforts inform best practices to help ready health care delivery systems for disasters and emergencies and are critical in aiding response and limiting the impact of disaster. As you all are aware, the United States is in the middle of influenza season. Many emergency departments are at 90 percent capacity. If influenza worsens, or if COVID–19 intensifies domestically, emergency departments would be severely strained, which is why supporting models such as the Hospital Preparedness Program health care coalition network is so important.

The National Ebola Training and Education Center (NETEC) combines the resources of health care institutions experienced in treating Ebola to offer training, readiness consultations, and expertise to help facilities prepare for Ebola and other special pathogens. The regional Ebola and other special pathogen treatment centers, of which ASPR and CDC funded 10 across the country, all have respiratory infectious disease isolation capacity or negative pressure rooms for at least 10 patients, including pediatric patients. The NETEC and the regional Ebola and other special pathogen treatment centers have been used to support recent quarantine efforts. Should the coronavirus infections increase domestically, these centers will become critical in isolating infected persons and providing adequate treatment.

ASPR and CDC also work to enhance medical surge capacity by organizing, training, equipping, and deploying Federal public health and medical personnel, such as National Disaster Medical System (NDMS) teams, and providing logistical support for Federal responses to public health emergencies. NDMS was originally created during the cold war to take care of military casualties from overseas in U.S. civilian hospitals. Today, NDMS teams are deployed to strategic locations across the coun-

try, caring for U.S. citizens who may have been exposed to SARS–CoV–2, effectively providing medical care and limiting the potential spread of the disease.

Recently, to assist in the repatriation effort, ASPR stood up a National HHS Incident Management Team (IMT) located in Washington, DC. The IMT serves as the National command-and-control element, deploying Public Health Service Commission Corps Officers and NDMS personnel.

In addition, HHS provided cache equipment, (e.g., medical supplies and resources) to Travis AFB, Marine Corps Air Station Miramar, Lackland, Air Force Base, and Camp Ashland to support evacuees quarantined at these facilities. HHS deployed one Disaster Medical Assistance Team (DMAT) and one IMT on February 12, 2020, to support American citizens in Japan on the Diamond Princess cruise ship, as well as the Embassy, to provide medical care, prescriptions, and behavioral health support.

Many active pharmaceutical ingredients and medical supplies, including auxiliary supplies such as syringes and gloves, come from China and India. This outbreak demonstrates why ASPR is seeking innovative solutions and partnerships to better protect National security. ASPR is working to increase access to personal protective equipment (PPE) by:

- Coordinating with CDC and other Federal agencies to share information about optimization of PPE, to prevnt overbuying and overuse of existing supplies.
- Engaging private-sector partners who manufacture and distribute PPE to share information and concerns, and to explore options to anticipate and meet the needs of the U.S. health care sector more effectively. During recent discussions, for example, distributors informed us that they have implemented allocations to help prevent stockpiling at health care facilities. The allocation is a percentage of a customer's previous orders and is designed to help protect the health care supply chain and ensure the right supplies are available for those who need it.
- We are also partnering with other Federal agencies such as DHS, DOD, and the U.S. Department of Veterans Affairs who are large buyers of PPE, to develop acquisition strategies that incentivize industry to expand PPE production while not exacerbating supply challenges.

The Strategic National Stockpile (SNS) holds thousands of deployable face masks, N95 respirators, gloves, and surgical gowns that could be deployed if State and local supplies are diminished due to the current COVID–19 response and commercial supplies are exhausted. The SNS is working hand-in-hand with commercial supply chain partners and other Federal agencies to continue monitoring supply levels and to prepare for a potential deployment of SNS personal protective gear if it is needed.

THE NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH) is the HHS agency leading the research response to the global health emergency of COVID–19. Within the NIH, the National Institute of Allergy and Infectious Diseases (NIAID) is responsible for conducting and supporting research on emerging and re-emerging infectious diseases, including COVID–19.

NIAID is well-positioned to respond rapidly to infectious disease threats as they emerge by leveraging fundamental basic research efforts; a domestic and international research infrastructure that can be quickly mobilized; and collaborative and highly-productive partnerships with industry. NIAID provides preclinical research resources to scientists in academia and private industry throughout the world to advance translational research for emerging and re-emerging infectious diseases. These research resources are designed to bridge gaps in the product development pipeline, thereby lowering the scientific, technical, and financial risks incurred by industry and incentivizing companies to partner in the development of effective countermeasures including diagnostics, therapeutics, and vaccines.

NIAID also supports the Infectious Diseases Clinical Research Consortium, which includes a network of Vaccine and Treatment Evaluation Units (VTEUs). The VTEUs conduct clinical trials to investigate promising therapeutic and vaccine candidates when public health needs arise. NIAID collaborates with other Federal agencies, including through the HHS Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), to help advance progress against newly-emerging public health threats. In addition, partnerships with academia, the biotechnology and pharmaceutical industries, domestic and international researchers, and organizations such as the World Health Organization (WHO) are integral to these efforts. NIAID has a long-standing commitment to coronavirus research, including extensive efforts to combat two other serious diseases caused by coronaviruses: SARS and MERS. This research has improved our fundamental understanding of

coronaviruses and provides a strong foundation for our efforts to address the challenge of SARS–CoV–2, the novel coronavirus that causes COVID–19. NIAID has responded to the newly-emerging COVID–19 outbreak by expanding our portfolio of basic research on coronaviruses. NIAID scientists have rapidly identified the human receptor used by SARS–CoV–2 to enter human cells. In addition, NIAID investigators and their collaborators recently identified the atomic structure of the spike protein, an important SARS–CoV–2 surface protein that is a key target for the development of vaccines and therapeutics. NIAID scientists also are evaluating the stability of SARS–CoV–2 on various ordinary surfaces and in aerosols to better understand the potential for viral spread throughout the community.

NIAID-supported researchers are assessing the risk of emergence of bat coronaviruses in China, including the characterization of bat viruses and surveys of people who live in high-risk communities for evidence of bat coronavirus infection. Such research is necessary to better understand this emerging infection and to investigate optimal ways to diagnose, treat, and prevent COVID–19.

The NIAID Centers of Excellence for Influenza Research and Surveillance (CEIRS), which conduct influenza risk assessments in multiple sites throughout the world particularly in Asia, have responded rapidly to the COVID–19 outbreak. CEIRS researchers at the University of Hong Kong are evaluating the epidemiology, transmission dynamics, and severity of COVID–19. These scientists also have performed environmental sampling of the Wuhan market where the first COVID–19 cases were reported.

NIAID is working with CEIRS collaborators and the CDC to obtain additional virus and biological samples from patients to further advance research efforts on COVID–19. Recently, the NIAID-funded BEI Resources Repository made samples of SARS–CoV–2 available for distribution to domestic and international researchers at Biosafety Level 3 laboratories. In addition, CEIRS researchers and other NIAID-supported scientists are developing reagents, assays, and animal models that can be used to evaluate promising therapeutics and vaccines. These research resources also will be shared with the domestic and international scientific community as soon as they become available.

On February 6, 2020, NIAID issued a *Notice of Special Interest regarding the Availability of Urgent Competitive Revisions for Research on the 2019 Novel Coronavirus.* This notice encourages existing NIAID grantees to apply for supplements for research project grants focused on the natural history, pathogenicity, and transmission of the virus, as well as projects to develop medical countermeasures and suitable animal models for preclinical testing of COVID–19 vaccines and therapeutics.

NIAID has responded to public health concerns about COVID–19 by increasing on-going coronavirus research efforts to accelerate the development of interventions that could help control current and future outbreaks of COVID–19. These activities build on prior NIAID research addressing other coronaviruses, such as those that cause SARS and MERS.

The CDC has developed a real-time Reverse Transcription-Polymerase Chain Reaction (rRT–PCR) test that can detect COVID–19 using respiratory samples from clinical specimens. NIAID is accelerating efforts to develop additional diagnostic tests for COVID–19, and NIAID-supported investigators are developing PCR-based assays for SARS–CoV–2 to facilitate preclinical studies and aid in the development of medical countermeasures. NIAID scientists also are developing reagents for an enzyme-linked immunosorbent assay for SARS–CoV–2. CEIRS researchers at the University of Hong Kong have developed a separate RT–PCR test and made their protocol publicly available through the WHO. These NIAID-supported investigators also have distributed assay reagents to 12 countries to facilitate the diagnosis of COVID–19.

NIAID is pursuing the development of antivirals and monoclonal antibodies for potential use against SARS–CoV–2. NIAID has launched a multicenter, randomized controlled clinical trial to evaluate the safety and efficacy of the antiviral drug remdesivir for the treatment of COVID–19 in hospitalized adults with laboratory-confirmed SARS–CoV–2 illness. The adaptive design of this trial will enable the evaluation of additional promising therapies. NIAID plans to assess other existing antivirals for activity against SARS–CoV–2, and NIAID scientists are working to identify monoclonal antibodies with therapeutic potential from COVID–19 patient samples as well as historical SARS patient samples. NIAID-funded scientists also aim to delineate new viral targets to facilitate the development of novel therapeutics with broad activity against coronaviruses. Finally, NIAID is expanding its suite of preclinical services to add assays that investigators can use to accelerate research and development of therapeutics for COVID–19.

A safe and effective vaccine for SARS–CoV–2 would be an extremely valuable tool to stop the spread of infection and prevent future outbreaks. Public and private entities across the globe have announced plans to develop SARS–CoV–2 vaccine candidates following the release of the SARS–CoV–2 genetic sequence. NIAID is supporting development of several SARS–CoV–2 vaccine candidates, and is utilizing vaccine platform technologies that have shown promise against the coronaviruses that cause SARS and MERS.

The NIAID Vaccine Research Center (VRC) is collaborating with the biotechnology company Moderna, Inc., on the development of a vaccine candidate using a messenger RNA (mRNA) vaccine platform containing the gene that expresses the VRC-designed spike protein of SARS–CoV–2. NIAID anticipates the experimental vaccine will be ready for clinical testing in the NIAID VTEUs within the next 2 months and will conduct preclinical studies as well as a first-in-human study of this COVID–19 vaccine candidate. The Coalition for Epidemic Preparedness Innovations (CEPI) will fund the manufacture of the first clinical production lot of this mRNA-based vaccine candidate using the Moderna rapid manufacturing facility.

NIAID Rocky Mountain Laboratories (RML) scientists are collaborating with Oxford University investigators to develop a chimpanzee adenovirus-vectored vaccine candidate against SARS–CoV–2; in addition, they have partnered with CureVac on an mRNA vaccine candidate. RML investigators also have launched a collaboration with the University of Washington and have begun early stage testing of an RNA vaccine candidate against SARS–CoV–2. In addition, NIAID-supported scientists at Baylor College of Medicine and their collaborators are evaluating an experimental SARS–CoV recombinant protein vaccine to determine if it also provides protection against SARS–CoV–2. NIAID is exploring additional collaborations with extramural research and industry partners on other vaccine concepts. NIAID also is supporting the development of standardized assays and animal models that will be utilized to evaluate vaccine candidates.

With all these efforts, NIAID is coordinating closely with colleagues at the CDC, BARDA, FDA, DOD, and other Federal and international partners.

To achieve the ultimate goal of having a SARS–CoV–2 vaccine available to the public, it is important that NIAID and the entire biomedical research community pursue a range of vaccine strategies in order to be better positioned to overcome the scientific or technical challenges associated with any particular vaccine approach. In this regard, NIAID has dedicated resources toward preclinical research to advance a robust pipeline of vaccine candidates into Phase 1 clinical evaluation. Further vaccine research, including Phase 2 clinical trials, will then be required. Additional research also is needed to better understand the fundamental biology of coronaviruses and to facilitate the design of vaccines that elicit optimal immune responses and protect against infection.

While on-going SARS–CoV–2 vaccine research efforts are promising, it is important to realize that the development of investigational vaccines and the clinical testing to establish their safety and efficacy take time. Although we plan to begin early stage clinical testing of an NIAID-supported vaccine candidate in the next few months, a safe and effective, fully licensed SARS–CoV–2 vaccine will likely not be available for some time. Currently, the COVID–19 outbreak response in the United States remains focused on the proven public health practices of containment—identifying cases, isolating patients, and tracing contacts.

NIH is committed to continued collaboration with other HHS agencies and additional partners across the U.S. Government and international community to advance research to address COVID–19. As part of its mission to respond rapidly to emerging and re-emerging infectious diseases throughout the world, NIAID is expanding our efforts to elucidate the biology of SARS–CoV–2 and employ this knowledge to develop the tools needed to diagnose, treat, and prevent disease caused by this virus. NIAID is particularly focused on developing safe and effective COVID–19 vaccines. These efforts also help to expand our knowledge base and improve our continued preparedness for the next inevitable emerging disease outbreak.

FOOD AND DRUG ADMINISTRATION

The FDA plays a critical role in overseeing our Nation's FDA-regulated products as part of our vital mission to protect and promote public health, including during public health emergencies. Our work primarily focuses on four key areas: First, actively facilitating efforts to diagnose, treat, and prevent the disease; second, surveilling product supply chains for potential shortages or disruptions and helping to mitigate such impacts, as necessary; third, conducting inspections and monitoring compliance, including of facilities that manufacture FDA-regulated products overseas; fourth, helping to ensure the safety of consumer products.

A key focus area for the FDA is helping to expedite the development and availability of medical products needed to diagnose, treat, and prevent this disease. We're committed to helping foster the development of critical medical countermeasures as quickly as possible to protect public health. We provide regulatory advice, guidance, and technical assistance to sponsors in order to advance the development and availability of vaccines, therapies, and diagnostic tests for this novel virus.

On February 4, 2020, the FDA issued an emergency use authorization (EUA) to enable immediate use of a diagnostic test developed by the CDC, facilitating the ability for this test to be used in CDC-qualified laboratories.[1] The FDA is dedicated to actively working with other COVID–19 diagnostic developers to help accelerate development programs and requests for EUAs. We have developed an EUA review template for tests to detect the virus, which outlines the data requirements for a Pre-EUA package that is available to developers upon request. To date, we have shared the EUA review template with more than 100 developers who have expressed interest in developing diagnostics for this virus.

The medical product supply chain is always potentially vulnerable to disruption, which makes our surveillance work and collaboration with industry critical and why the agency takes a proactive stance on any potential impact or disruption to the supply chain. An outbreak of this global scale has an impact on the medical product supply chains, including potential disruptions to supply or shortages of critical medical products in the United States. We are in contact with manufacturers; global regulators, like the European Medicines Agency; health care delivery organizations; and other participants in the medical product supply chains to quickly identify and address any supply concerns that come from issues related to China and other locations in Southeast Asia sourcing raw materials for manufacturing drugs.

We are also tracking reports of increased ordering of some essential medical devices through distributors, such as personal protective equipment (PPE) (e.g., respirators and surgical gowns, gloves and masks). FDA is working proactively to stay ahead of potential shortages or disruptions of medical products. The agency will use all available authorities to react swiftly and mitigate the impact to U.S. patients and health care professionals as these threats arise.

Monitoring the safety of FDA-regulated product supply chains is one of the FDA's highest priorities. The FDA utilizes risk-based models to identify firms for inspection and prioritizes inspections based on specific criteria. Because of travel restrictions to China, the agency has postponed planned inspection activities in China. However, we are currently continuing inspection and enforcement activities as normal for the rest of our operations. Inspections of facilities in China remain prioritized in our site selection model and, when travel restrictions are lifted, inspections of facilities in China will resume. Any travel to China that is deemed to be mission-critical is being assessed on a case-by-case basis in close coordination with other HHS components and with the Department of State. FDA is committed to maintaining its scheduled inspections around the globe to the extent possible, while maintaining the safety of the staff involved. We will revisit this approach and adjust as necessary as this outbreak continues to unfold. In the mean time, FDA is working with our partner government agency, U.S. Customs and Border Protection (CBP), to evaluate and adjust our risk-based targeting strategy to ensure FDA-regulated products are safe when entering the United States.

While the outbreak is impacting our ability to conduct inspections in China, it's important to underscore that the FDA's regular risk-based process of surveillance testing of imported products, including those from China, continues.

Inspections are one of many tools that the agency uses to inform its risk strategy for imported FDA-regulated products and to help prevent products that do not meet the FDA's standards from entering the U.S. market. Other tools include: Import alerts, increased import sampling, and screening. Inspections are also part of, among other things, the new and generic drug approval process. While such pre-approval inspections are on hold in China, we are working to mitigate the impact on new and generic drug approval decisions by requesting records that may be used in lieu of an inspection, depending on the circumstances. Based on our evaluation of previous FDA inspection history, a firm's previous compliance history and information from foreign health authorities with which we have mutual recognition

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[1] FDA. 2019 Novel Coronavirus Emergency Use Authorization. February 4, 2020. *https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#coronavirus2019*. FDA. FDA Takes Significant Step in Coronavirus Response Efforts, Issues Emergency Use Authorization for the First 2019 Novel Coronavirus Diagnostic: Critical Milestone Reached in Response to this Outbreak. *https://www.fda.gov/news-events/press-announcements/fda-takes-significant-step-coronavirus-response-efforts-issues-emergency-use-authorization-first.*

agreements, we determine if the totality of the information would suffice in lieu of such a pre-approval inspection.

All products offered for entry into the United States, including items for personal use, are subject to the regulatory requirements of CBP. Imported shipments of FDA-regulated products referred by CBP, including those from China, are then reviewed by the FDA and must comply with the same standards as domestic products. At this time, we want to reassure the public that there is no evidence to support transmission of COVID–19 associated with imported goods, including food and drugs for people or pets, and there have not been any cases of COVID–19 in the United States associated with imported goods.

We established a cross-agency task force to closely monitor for fraudulent FDA-regulated products and false product claims related to COVID–19 and we have already reached out to major retailers to ask for their help in monitoring their online marketplaces for fraudulent products with coronavirus and other pathogen claims.

FDA is utilizing all our existing authorities to address COVID–19 and we welcome the opportunity to work with Congress to strengthen our response capabilities. There are 4 specific proposals included in the President's budget that would better equip the agency to prevent or mitigate medical product shortages.

(1) Lengthen Expiration Dates to Mitigate Critical Drug Shortages

Shortages of critical drugs can be exacerbated when drugs must be discarded because they exceed a labeled shelf-life due to unnecessarily short expiration dates. By expanding FDA's authority to require, when likely to help prevent or mitigate a shortage, that an applicant evaluate, submit studies to FDA, and label a product with the longest possible expiration date that FDA agrees is scientifically justified, there could be more supply available to alleviate the drug shortage or the severity of a shortage.

(2) Improving Critical Infrastructure by Requiring Risk Management Plans

Enabling FDA to require application holders of certain drugs to conduct periodic risk assessments to identify the vulnerabilities in their manufacturing supply chain (inclusive of contract manufacturing facilities) and develop plans to mitigate the risks associated with the identified vulnerabilities would enable the agency to strengthen the supply chain by integrating contingencies for emergency situations. Currently, many applicants lack plans to assess and address vulnerabilities in their manufacturing supply chain, putting them, and American patients, at risk for drug supply disruptions following disasters (e.g., hurricanes) or in other circumstances.

(3) Improving Critical Infrastructure Through Improved Data Sharing: Requiring More Accurate Supply Chain Information

Empowering FDA to require information to assess critical infrastructure, as well as manufacturing quality and capacity, would facilitate more accurate and timely supply chain monitoring and improve our ability to recognize shortage signals.

(4) Device Shortages

FDA does not have the same authorities for medical device shortages as it does for drugs and biological products. For instance, medical device manufacturers are not required to notify FDA when they become aware of a circumstance that could lead to a device shortage or meaningful disruption in the supply of that device in the United States, nor are they required to respond to inquiries from FDA about the availability of devices. Enabling FDA to have timely and accurate information about likely or confirmed national shortages of essential devices would allow the agency to take steps to promote the continued availability of devices of public health importance. Among other things, FDA proposes to require that firms notify the agency of an anticipated meaningful interruption in the supply of an essential device; require all manufacturers of devices determined to be essential to periodically provide FDA with information about the manufacturing capacity of the essential device(s) they manufacture; and authorize the temporary importation of certain devices where the benefits of the device in mitigating a shortage outweigh the risks presented by the device that could otherwise result in denial of importation of the device into the United States.

Ms. UNDERWOOD. I thank all the witnesses for their testimony. I will remind each Member that he or she will have 5 minutes to question the panel. I now recognize myself for 5 minutes.

Americans want to know what they should expect in the coming weeks and months. Our State and local public health work force

and our health care system leaders need to know so they can do everything that they can to be prepared. Dr. Redd, I am looking for numbers here. What are the current upper and lower estimates of total deaths due to the coronavirus that we should expect in the United States?

Dr. REDD. So I don't have an exact answer to that question. I think it is an important question. I think that there is a lot that depends on how aggressive our public health interventions are to really determine the ultimate course of this epidemic.

Ms. UNDERWOOD. OK.

Dr. REDD. There are many unknowns.

Ms. UNDERWOOD. Yes, sir. What are the upper and lower estimates for hospital and ICU admissions?

Dr. REDD. I would give the same answer I gave to the previous question. The intensity of our public health intervention measures will determine the ultimate impact of this pandemic.

Ms. UNDERWOOD. OK. Then at current rate to detection spread, when will California and Washington State run out of ICU beds and then also hospital beds?

Dr. REDD. Again, the better and more intensive our interventions are, the lower those numbers will ultimately be.

Ms. UNDERWOOD. Do you expect CDC to do modeling that will be widely reported through like an MMWR or something like that?

Dr. REDD. A number of groups are doing that modeling. I am not sure what our plans are. We are in communication with modelers from the United Kingdom around the country on those sort of things.

A lot of that has to do with estimating the value of interventions that might be undertaken and where they would have the greatest impact. So I am not—I don't know whether or not those things from inside will be published, but there is a lot of information out there already.

Ms. UNDERWOOD. OK. For our health system to prepare to handle a surge in patients while protecting its work force, providers need to be able to test every patient who meets the criteria based on symptoms and exposure. But we know that right now as the Governor of Illinois just said this morning, not everyone who should be tested has been.

Dr. Redd, since December how many Americans who meet the current criteria for being tested have actually been tested and received their results?

Dr. REDD. I can give you the number of people who have been tested. Let me, let me find that in my cards here.

Ms. UNDERWOOD. OK.

Dr. REDD. The guidance has changed as you know recently——

Ms. UNDERWOOD. I know.

Dr. REDD [continuing]. To allow——

Ms. UNDERWOOD. That is why we are asking about the current criteria, sir.

Dr. REDD. Right. I think we are around a little bit more than 1,700 people have been tested by CDC. There is a lot of testing happening in State health department——

Ms. UNDERWOOD. I understand that.

Dr. REDD [continuing]. Labs now. Let me—if I might—take the opportunity to talk about—and tell me if you want——

Ms. UNDERWOOD. Well, Dr. Redd, what we are really trying to understand is the number of tests that have been completed, how many tests need to be done to accurately depict community levels that spread in the United States. Do you have that figure?

Dr. REDD. I—what I would like to do is walk through how the laboratory testing works in the United States.

Ms. UNDERWOOD. OK. Dr. Redd, we have heard that briefing several times here in the Congress. We have some very specific questions, sir. What is your plan to support States and communities to get those tests done? When will that be done?

Dr. REDD. So we have taken aggressive action over the last several weeks—CDC has sent materials sufficient to test 75,000 people through the public health system.

Ms. UNDERWOOD. Right.

Dr. REDD. There are over a million tests available through the commercial system.

Ms. UNDERWOOD. Yes, sir.

Dr. REDD. Both of those numbers are increasing as we speak.

Ms. UNDERWOOD. Right. But my question, sir, was what is your plan to support the States to get those tests done for every single person who should be tested that meets the current criteria? There is a big gap between 1,700 and 75,000 and a million. Those are the 3 numbers you just outlined for us now.

Dr. REDD. That is true. The—I think that there are 2 different systems in play here. In the public health system—and this is not just for this disease but in general, the role of the public health laboratories are to detect cases early of new diseases and then to be able to do—representative testing to estimate the overall burden of disease.

Ms. UNDERWOOD. Right.

Dr. REDD. There is a separate system, the clinical system, which is really for clinical care——

Ms. UNDERWOOD. Yes, sir.

Dr. REDD [continuing]. To make sure that a person gets treated for the right disease that we don't assume that he has COVID–19 when there is different treatable disease. That is the much larger capacity that has actually being implemented rapidly compared with previous efforts with new diseases.

Ms. UNDERWOOD. OK. I am going to stop you right there, sir. Is every test result from both the public and the private labs being fed into the Flu Surveillance System? Yes or no?

Dr. REDD. Right now the—we are working to include the commercial laboratories in that system. The large commercial systems are being included. The public health laboratories are being included. There are others that are going to be kind of outliers that we will work to include, but that would be the ultimate aim.

Ms. UNDERWOOD. OK. While there is still a lot that we don't know about the pathology of the coronavirus, we are seeing that seniors are among those experiencing higher mortality rates.

So in addition to the coronavirus.gov that we both spoke about, CDC has a coronavirus information hotline as I am sure you are

aware for those who don't have internet access or who may not be as internet savvy, like some seniors.

When the committee staff called the hotline, they consistently faced wait times of 30 to 60 minutes. How is CDC working to improve its hotline?

Dr. REDD. Let me get back to you on that. I think that is a very important thing that needs to be corrected——

Ms. UNDERWOOD. OK.

Dr. REDD [continuing]. And something to take action on that.

Ms. UNDERWOOD. Just more broadly, sir, our job is to steer the Federal Government toward the best possible outcome for public health. Modeling estimates help us evaluate outcomes. Surveillance informs modeling. Tests inform surveillance. We need to get all 3 right, sir. We will be making some really important decisions without a comprehensive view of what we are facing.

So Dr. Redd, we are going to be sending over some follow-up questions for you in writing. We would appreciate your help in ensuring a prompt response. Thank you.

I now recognize the Ranking Member of the full committee, the gentleman from Alabama, Mr. Rogers, for questions.

Mr. ROGERS. I thank you. Mr. Cuccinelli, this morning the CDC director said Europe is the new China in terms of outbreak. Is CBP doing more screenings of international travel from European countries to the United States?

Mr. CUCCINELLI. So as each country or in this case region becomes more and more problematic, it obviously gets reviewed on a day-to-day basis. I would tell you that it isn't just CBP. TSA is involved. CDC is involved. This is one of the things that the task force has considered literally on a daily basis as we have watched this pandemic move around the globe.

As you know, I am sure there is exit screening going on in Italy in particular, but Europe presents a unique problem. Because of the Schengen zone where their borders effectively don't—they don't have borders for purposes of travel, there are 29 countries that we have to confront here.

The question arises, does treating—we will take Italy. We will continue with Italy. Italy in the fashion we would China or even South Korea as a unitary entity even makes sense.

So what the task force came to with respect to Italy, is we are testing—in fact, the Italian government is doing it on the exiting side for direct flights to the United States. That is about half of those flights—very close to half. They have dropped from above 7,000 to just above 1,000 a day.

So the—there has been a substantial drop in that travel. The reason that we chose not to expend the resources to capture the indirect flights is by way of scale—don't hold me to these exact numbers—to capture the last 2-, 3-, 4,000 travelers from Italy depending on the day—and that was at full flight capacity—would require screening approximately 100,000 people.

Those are resources that just—relative to the cost benefit—were more appropriate to apply to public health efforts other than that screening. So in Korea and Italy, we have allies who we trust and who are transparent doing exit screening.

We are of course doing entrance screening for those from Iran and China or who have been through there. But the question is a live question, Congressman, about how to treat Europe as a whole. You have seen Department of State and CDC——

Mr. ROGERS. Right.

Mr. CUCCINELLI [continuing]. Warnings go up. That is not to the level of using legal authorities to block travel yet, but it is under consideration.

Mr. ROGERS. Well, and it should be. That is the reason I brought it up. Right now, we are just dealing with a handful of those countries as you know.

Mr. CUCCINELLI. Right.

Mr. ROGERS. Given the freedom of travel throughout the European Union, my view is we should be treating it as a region as a unit and, and expecting them accordingly. Let me ask—you know, we just passed in a bipartisan fashion an $8.3 billion supplemental to help with this. I know a lot of that is going toward vaccine development.

Mr. CUCCINELLI. Right.

Mr. ROGERS. But it went from $2.5 billion to $8.3 billion real fast. Tell me how that money is broken out. What are you going to do with it?

Mr. CUCCINELLI. Well, as you probably know, the money that DHS receives comes through HHS. So I will give you an example: FEMA has been with ASPR since—for about a month now at their request as the lead Federal agency in HHS and are—FEMA is reimbursed for those services effectively through interagency agreements.

So the dollars you are describing from the supplemental that reached DHS come through HHS in exchange for services in accordance with the law.

Mr. ROGERS. Is it just FEMA or won't CBP to get some of that money?

Mr. CUCCINELLI. Right now, it is just FEMA. CBP, CWMD, the Coast Guard, TSA are all operating out of their base budgets for all the work they are doing——

Mr. ROGERS. Do you expect——

Mr. CUCCINELLI. As is the, you know, S&T as well.

Mr. ROGERS. Do you expect that to be sufficient given the——

Mr. CUCCINELLI. For the moment, we do. Yes. Some things would have to change for that to not be sufficient but so far none of those conditions have arisen.

Mr. ROGERS. Doctor Redd, the Chinese government failed to give us notice for 2 months from the time of the outbreak until they did make the international community aware. What damage did that do to our ability to deal with this in a better fashion if any that you are aware of?

Dr. REDD. You know, I think there are some things that they did well and others that they didn't. Reporting the outbreak quickly, posting the sequence of the new virus—there did appear to be a period of time when probably things were going on that weren't getting out of China.

I think there were questions about whether there was human-to-human transmission that initially it appeared it might be just peo-

ple exposed to animals. So I think that, that was a period of time when we were—there is not really anything we would have done differently. We were working on a diagnostic test. We were sending materials that started the ball rolling on vaccine production.

We—you know, as you know within weeks of identifying the outbreak, it really—the restriction of travel from China reduced travel by 90 percent. I think that was a very helpful move to prevent more cases from China coming into the United States.

Mr. ROGERS. Thank you. Madam Vice Chair, I yield back.

Ms. UNDERWOOD. The Chair will now recognize Members for questions that they may wish to ask the questions. In accordance with our committee rules, I will recognize Members who are present at the start of the hearing based on seniority in the committee alternating between Majority and Minority.

Those Members coming in later will be recognized in the order of their arrival. The Chair recognizes for 5 minutes the gentleman from Mississippi, Mr. Thompson.

Chairman THOMPSON. Thank you very much, Madam Chair. In my earlier comments, I talked about the importance of transparency and communication. The public only gets what we tell them. If we don't tell them accurately, then it is misinformation.

The best example I can share in my opening statement the very first briefing we got we were told that there is a 800 number. The briefers—as Members of Congress—the briefers didn't know the 800 number. They had to get the number and bring it to us.

Now, I hear that the number is working, but if as a member of the public who would call and be put on hold for 30 to 60 minutes. It just absolutely too big a problem. So I hope that you—you look at it.

Two of the people we heard from last week—one was a former head of CDC and the other was a respected researcher from John Hopkins—they made it very clear to us that communication is—and transparency in this kind of situation is absolutely important.

So Dr. Redd, can you tell me if the coronavirus task force is carrying out its meeting at a Classified level or are they open?

Dr. REDD. I know that the meetings are being held in a Classified facility. I don't think that they are Classified.

Chairman THOMPSON. Well, I want you to check because I think there are some challenges in that arena because they are in fact Classified. Part of the problem a lot of us are having is an over classification of information to the point that the public doesn't know. So look at that.

Dr. REDD. Actually, I would like to agree with your major point, which is I agree that communication and information is a critical took in combating the outbreak.

People need to know what is happening. They need to know what kind of actions they can take to protect themselves. It is really one of the most important tools that we have at this point.

Chairman THOMPSON. So in line with the Chairperson's question, how many test kits do we have as of today?

Dr. REDD. So on the public health side, 75,000. On the commercial side, over a million—somewhere between 1- and 2 million right now. The numbers are increasing rapidly.

Chairman THOMPSON. So how would the test kits be dispersed?

Dr. REDD. So on the public side they go to State health department laboratories and other laboratories that are a part of our network for influenza surveillance. Actually, on the commercial side it is however that system normally works. So it depends on the company. Some of them have——

Chairman THOMPSON. Well——

Dr. REDD [continuing]. Facilities.

Chairman THOMPSON. Well, you know, we trying to help the public—you are tell them we have a million test kits, but if somebody from CDC in your position can't explain to me how the public can access those kits that is not very helpful.

Dr. REDD. I agree with that. I think that what people need to do if they feel that they are in need of a test is—the first thing would be to call their doctor. The doctor would then—depending on how they have access to the test—it could either be through the commercial system or it could be through the public health system——

Chairman THOMPSON. So——

Dr. REDD [continuing]. That person——

Chairman THOMPSON. Are those 75,000 test kits that you talked about that are publicly available, does that address all of the current needs here in the United States?

Dr. REDD. It doesn't. It doesn't. That is why the commercial manufacturers are such an important part of this——

Chairman THOMPSON. Absolutely. But are they talking to each other?

Dr. REDD. So I—I have——

Chairman THOMPSON. Well——

Dr. REDD. I mean——

Chairman THOMPSON. Get back to us.

Dr. REDD [continuing]. Basically yes. You know, I think the answer is——

Chairman THOMPSON. Well, I mean——

Dr. REDD [continuing]. Yes.

Chairman THOMPSON. You know, we are trying to give the public some comfort that if you say we have a million kits then there is a process that is defined for those million kits to be accessed.

We don't have that based on what you are telling me. I think one of the reasons we are here today is to put some clarity on how we address this situation.

Dr. REDD. Yes, sir. I think that people—I think that the patient experience here is really critical. And that when they need a test, they can get one quickly and get the results quickly. That is the aim that we are——

Chairman THOMPSON. OK.

Dr. REDD [continuing]. Hoping to achieve.

Chairman THOMPSON. Thank you. If the Chairwoman will indulge me just for—Mr. Cuccinelli, on March 1, 2020 a District Court Judge ruled that you were not lawfully appointed to serve as the acting director of USCIS and that accordingly the reduced time to consult and prohibitions on extensions directed must be set aside.

Are you still serving the senior—as a senior official performing the duties of director of USCIS in opposition to what the court ruled?

Mr. CUCCINELLI. No, sir. The court ruled that in my position as principle deputy at USCIS I was not properly occupying the position of acting director of USCIS. That is obviously something we are still analyzing and obeying the court order with respect to the 5 plaintiffs.

My current position as senior official performing the duties of the deputy secretary derives not from my previous capacity as acting director of USCIS, but from my official position as principle deputy of USCIS.

So my—as I perform the rules I am here doing today as a senior official performing the duties of deputy secretary that is not affected by the court's ruling. The court did not rule that I am inappropriately occupying my current position. It was the prior position.

Chairman THOMPSON. So that is your interpretation of the court's order?

Mr. CUCCINELLI. No, sir. That is the ruling.

Chairman THOMPSON. Well, I would—have you had the counsel——

Mr. CUCCINELLI. Yes.

Chairman THOMPSON [continuing]. From DHS look at that?

Mr. CUCCINELLI. Yes, sir.

Chairman THOMPSON. Did they provide you something in writing?

Mr. CUCCINELLI. No, sir.

Chairman THOMPSON. So how did—what, they just told you?

Mr. CUCCINELLI. Well, it is pretty simple and straightforward Mr. Chairman. So it wasn't hard for them to explain it to me.

Chairman THOMPSON. Well, I would—as Chair, we would like to get it in writing because I think the court was fairly clear that your present position was not consistent with the law. Any way of trying to massage it just gets around it, but I—we will look forward to getting that correction. I yield back.

Ms. UNDERWOOD. The Chair now recognizes the gentleman from New York, Mr. Katko, for 5 minutes.

Mr. KATKO. Thank you, Madam Chair. Mr. Cuccinelli, is there anything else you want to add to the last line of inquiry before we proceed——

Mr. CUCCINELLI. Just——

Mr. KATKO [continuing]. To other questions?

Mr. CUCCINELLI. I would just point out the time line. It might help understand the ruling. The case was filed last summer when I was serving as the acting director of United States Citizenship and Immigration Services as assuming that vacant slot from my position as principle deputy.

The hierarchy if you will of the deputy secretary position as it currently stands traces back to the principle deputy for the United States Citizenship and Immigration Services. It does not trace back to either the director or acting director phrased in any way.

That is why I gave the answer to the Chairman that I did. It was why I got the legal advice from counsel at DHS that I did.

Mr. KATKO. Thank you, sir. Doctor Redd, I want to drill down a little farther on the previous line of our inquiry as well. I am trying to get a handle.

So you have 75,000 tests in a Government—I mean in the Government sector. You have a million tests in the private domain. What happens—what is going to happen to those million tests? Where do they go?

Dr. REDD. So those—the purpose of those tests would be clinician, a doctor nurse practitioner, physician's assistant could order a test and that would go just the way any test you would get in a doctor's office would go.

It would be sent to a commercial laboratory either at the hospital or one of the large companies. You would get a test result. It would come back to your doctor. We are working on making sure that, that information also is funneled into the Government so we will be able to track those tests.

But it is essentially a way of providing a test that can be used for clinical services where public health testing generally is to detect the first cases and then to really to do surveillance. You don't have to test every case to do surveillance, but for clinical care you do need a test for each person.

Mr. KATKO. I just want to make sure I understand this. Is it fair to say that you have the million tests that are already available, plus you have 75,000 more tests? All of them are getting in front line one way or another for testing of patients?

Dr. REDD. Yes, sir.

Mr. KATKO. OK. How much more—are going to be expected the next few weeks that are going to be produced?

Dr. REDD. So the time line I am not so sure on, but it is going to be additional millions of tests in the commercial sector.

Mr. KATKO. OK. Good. That is good to hear. Now, when we get these tests out there, it is fair to say that these numbers are going to go up, the number of positive tests are going to go up and go up significantly; is that correct?

Dr. REDD. I think that is fair to say that we are going to identify additional cases with more testing.

Mr. KATKO. OK. As these numbers go up, you are going to have to act according on what has been considered by the World Health Organization now a pandemic.

I think we need to have the American people prepared for the fact that we are going to have a very serious rise in the number of cases. Has there been any estimates as to what they think it is going to be, the numbers next month or so?

Dr. REDD. So I think the total numbers really depend on the aggressiveness and intensity and effectiveness of our public health measures. One of the things that is happening and just in our strategy to respond, early on we wanted to identify every case, identify the contacts of that case, recommend self-monitoring to prevent further spread.

At this point, the individual measures in some parts of the country where there is intense community transmission, those measures are not appropriate. That there are more important things to do.

That is really when we shift to a community measures such as making sure nursing homes are especially protected, canceling large gatherings, recommending as we have that people that are at

risks, seniors and people with chronic medical conditions, take different steps to protect themselves from becoming exposed.

So it is a shift from a kind-of an individual level case tracking to something that is broader and applies to entire communities.

Mr. KATKO. As a matter of precaution, should we be doing any of those things now and not waiting until they get all these positive tests? What should we be doing now?

Dr. REDD. We should. In fact, we are in King County, Washington; in Santa Clara County; in New York City. There are—in fact today—I think maybe just as the hearing started, there was guidance posted based on—a guidance document they released a few days ago but tailored specifically for King County and Santa Clara working with the health departments on, you know, what does it mean to actually apply this guidance to your community at—in the situation that you are in right now.

I think that the—in general these measures are more effective the earlier they are implemented. We have seen that in other parts of the country—or world in Singapore, Hong Kong where they are taking very aggressive measures, and in those cases had a really good success in preventing the kind of transmission that we would like to prevent.

Mr. KATKO. Last, the line—the lab testing. Could you just briefly explain to us just so we are clear, how does the lab testing actually work?

Dr. REDD. So a specimen is obtained from a person. We are actually—the way that it has been—now is a nasal specimen. So there is a device that is stuck in the person's nose to collect a specimen, a throat swab that is put in transport medium, is transported to a laboratory.

There is a process of denaturing that specimen that might contain a virus. That denatured specimen is then put into a machine that assays for specific parts of the nucleic acid, the genetic material of the virus.

There are also a set of positive controls so to make sure the test would find if it is there, and negative controls to make sure if it is not there it wouldn't be detected. That then yields a yes or a no result.

It also can tell you the concentration—something that is called cycle threshold. That is basically the number of times the machine has to go through this cycle. So a high number means there is not that much virus there. A low number means there is a lot.

Mr. KATKO. All right. Thank you very much. I yield back, Madam Chair.

Ms. UNDERWOOD. The Chair now recognizes the gentlelady from New York, Miss Rice, for 5 minutes.

Miss RICE. Thank you, Madam Chairwoman. Mr. Cuccinelli, during the past public health crisis like Ebola and H1N1, the Department of Homeland Security played a pivotal role in a clear and coordinated Federal Government response.

With the coronavirus, our State and local governments have stepped up to fill this role. States like New York have had to respond quickly to deploy emergency management and to work with local partners to keep our citizens safe. They instead of your agency are at the front lines of this outbreak.

So for some reason it appears—and maybe you can enlighten me if I am wrong that DHS has not been on the front lines like they have in prior epidemics? So could you clearly state what DHS's role has been in responding to the coronavirus and what you see as your role going forward?

Mr. CUCCINELLI. Certainly. As we move further and further away from containment which is where the Department of Homeland Security has a significant role and into mitigation which we have been doing for weeks now, as Doctor Redd has referenced implicitly a number of times, the front lines folks in just pure volume of numbers are your local and State public health authorities.

This is—we are following the pandemic plan put in place 2 years ago which was the most recent iteration of that plan. It in fact calls for extensive cooperation with the Federal Government supporting local and State efforts.

The sheer number of medical and health care professional personnel required to address a pandemic like this puts us in the position of necessarily relying on State and local officials to be frontline fighters in this effort.

I will give you an example. When we saw the Grand Princess problem developing off the coast of California, we had a unified command set up between the Coast Guard, CDC, California.

But in practical terms, because those people were going to land in California, were most likely to be impacting California health care facilities and capacity, California very much had the lead and did a great job with it. We are being very careful not to step on States or to tell them what to do. We are partnering with them as best we can, so——

Miss RICE. OK. Thank you. I am just going to stop you there.

Mr. CUCCINELLI. Sure.

Miss RICE. It is now being reported that my home State of New York, we have almost 200 cases of the coronavirus which makes it one of 3 States with the highest number——

Mr. CUCCINELLI. Yes.

Miss RICE [continuing]. Of cases. Before this hearing, I spoke with the head of the Department of Health in Nassau County, which is on Long Island which my district is—fully encompassed in.

I asked him—you know, I said that I was going to be at a hearing with you. I said is there anything that you need that you don't have that the Federal Government can provide?

He said what we really need—because now they are seeing more significant cases of community spread; for instance, in my district alone, the number of infected people has quadrupled since Sunday.

Mr. CUCCINELLI. Right.

Miss RICE. So I asked him what can the Federal Government do? He said, you know, what we would love is some guidance as to what public events should be canceled, what public events should not be canceled.

Dr. Fauci testified today that large sporting events should be banned. So what is your guidance? They are looking to the Federal Government for some guidance on that issue so there can be a—so we don't increase the panic. And——

Mr. CUCCINELLI. Right.

Miss RICE [continuing]. That States are not doing different things and getting people all riled up when they don't need to be.

Mr. CUCCINELLI. Well, we—in the Department of Homeland Security, we essentially operationalize CDC guidance. We look to the CDC's guidance as well, and because of the novelty of this virus it has been changing. I know—I will turn it over to Dr. Redd, but——

Miss RICE. Well, let me just stop right there. OK. So I will follow up——

Mr. CUCCINELLI. OK.

Miss RICE [continuing]. With my question. I just wanted to ask you—Dr. Fauci also said "We would recommend that there not be large crowds." Would you consider a political rally in an arena that is filled to capacity with between 8- and 12,000 people—would you consider that a large crowd?

Mr. CUCCINELLI. We would consider probably anything over 1,000 people a large crowd.

Miss RICE. OK. Doctor, if you could—the questions that Mr. Cuccinelli——

Dr. REDD. Yes, I think that the purpose of the gathering wouldn't determine whether it would be, you know——

Mr. CUCCINELLI. Right.

Miss RICE. Well, let me—do you agree with Dr. Fauci on that, that there should not be—that he said we would recommend that there not be large crowds? Would you recommend with him?

Dr. REDD. I would.

Miss RICE. Would you, Mr. Cuccinelli?

Mr. CUCCINELLI. Again, we look to the medical professionals for that——

Miss RICE. I am asking your opinion.

Mr. CUCCINELLI. Guidance.

Miss RICE. You are in this for DHS.

Mr. CUCCINELLI. I am sorry. I am not going to give you my opinion. I will tell you the opinions I look to operationalize when we do our jobs.

Miss RICE. But do you agree with what——

Mr. CUCCINELLI. Dr. Redd.

Miss RICE [continuing]. Dr. Redd is saying?

Mr. CUCCINELLI. Well, I certainly——

Miss RICE. Yes or no.

Mr. CUCCINELLI [continuing]. Look to his employer for CDC for where we——

Miss RICE. Why can't you answer this question?

Mr. CUCCINELLI. Well, I am sorry. I don't know that it is a can't——

Miss RICE. Is it because the President has said that he has no plans to not have people—thousands of people gathered together in large crowds? Is that why? Because Dr. Redd——

Mr. CUCCINELLI. So when we had this——

Miss RICE [continuing]. Said it in 2 seconds——

Mr. CUCCINELLI [continuing]. Decision to make——

Miss RICE [continuing]. That he agreed with Dr. Fauci. Can you please give me a yes or no answer? Do you agree with Dr. Fauci when he said we would recommend that there not be large crowds?

Mr. CUCCINELLI. I am not prepared to do that.

Miss RICE. OK. That is quite unbelievable. I think my time is up. Thank you, Madam Chairwoman.

Ms. UNDERWOOD. The Chair now recognizes for 5 minutes the gentleman from North Carolina, Mr. Walker.

Mr. WALKER. Yes. Do you need another minute to kind-of go into detail or are you satisfied with that answer?

Mr. CUCCINELLI. Congressman, when we had this decision that we had to make last week, it wasn't 1,000 people; it was about 200 at our Seattle office. We took into account what the local authorities were doing. That was part of our decision-making process.

We will adjust our decision making based on what is going in the particular community at issue. Would I have less reluctance in agreeing with Dr. Fauci if we were talking about Seattle? Yes. Then if we were in the middle of, you know, an area of a State that was not experiencing interruption.

Mr. WALKER. Sure. So it is——

Mr. CUCCINELLI. Absolutely.

Mr. WALKER [continuing]. Is subjective. I know our Democratic Governor just ruled that the NCAA tournament there in North Carolina should move. So some of this could be geographically influenced? Would you agree?

Mr. CUCCINELLI. Absolutely. Again depending on what is going on in that local area.

Mr. WALKER. What procedures do have in place—specific question here. I was recently in the Rio Grande Valley border. Over 60 different countries—or migrants from 60 different countries had been apprehended.

This year alone I believe several hundred Chinese nationalists have been apprehended as well. The procedures in place if you arrest a migrant that is showing size of respiratory problems, how do you handle that? Do you separate them or isolate them? What is the procedure in handling this?

Mr. CUCCINELLI. So we have prior to the existence of this virus in place standard operating procedures because we do confront communicable disease on the Southwest Border with a certain degree of regularity. Those folks are transferred to ICE. They have quarantine procedures.

If that is not available, CBP is in a position of having to rely on local health care systems to provide that support. Those are the two avenues we have.

Mr. WALKER. I appreciate that. Dr. Redd, thanks again for your long-term service. I appreciate what you are doing. There are reports that there are two strains of this virus. If the virus continues to mutate, does this possibly slow efforts to develop a vaccine or contain in other aspects?

Dr. REDD. Well, viruses that have the genetic material—ribonucleic acid—when they—they naturally mutate. In fact, the—when we do sequencing we actually get a bunch of different viruses. There is a consensus sequence. So I think that they just naturally mutate.

I don't think we can predict what will happen with the virus. It would be unusual for there to be enough mutation that a vaccine that we would produce against a strain now wouldn't work because of that kind of drift.

Mr. WALKER. We had a very strong presentation yesterday—from Doctor Scott Gottleib who was pointing out the fact that he believes in his opinion that this will slow down in the summer or dissolve a good bit but have maybe a potentially a small spike back in the fall. Is that what you guys are seeing as well?

Dr. REDD. I think we hope that in the summer we will see a drop in transmission. I don't think we can say that we know that. That what you are describing is what happened with H1N1 where we had a fall—or a spring wave. Things went low in the summer—still had more flu than usual in the summer. Then in August and September, we saw a big increase.

I think that, that does—if that were to happen, it would be a great thing because it would give us time to be more prepared for that fall wave.

Mr. WALKER. Right. Traditionally the flu follows that pattern; is that correct?

Dr. REDD. That is true.

Mr. WALKER. OK. We talked about it already. The World Health Organization has now listed this as a pandemic. Does that modify your guys' approach or change anything as far as the way you are moving forward with it?

Dr. REDD. It really doesn't. I think what that declaration was something that people working in this already knew that it is around the world, and there is lots of community transmission around the world.

Mr. WALKER. OK. Thank you. Time for another question with Mr. Cuccinelli. Do you have a plan for FEMA should an area that is the center of outbreak—we were just talking about geographic and maybe demographics as well—if there is an outbreak that could be considered maybe a natural disaster? How does those two connect and what is your role in this?

Mr. CUCCINELLI. So you are probably familiar with our IMAT teams that get deployed; for instance, Tennessee just had devastating tornados. FEMA deployed its IMAT teams and them followed up with support.

What we are designed around at FEMA is fairly large IMAT teams to respond to a natural disaster as you describe. But here we can and are seeing eruptions all around the country.

So what FEMA has done is they have broken their IMAT teams down into smaller teams so there is at least one for every single State and territory. They are smaller 4- or 5-person teams. They have been trained specifically to support States and local officials under these circumstances obviously different from a natural disaster.

So we have adjusted our personnel—that is what we have been doing with some of this time is changing our set up, our structure, and our ability to reach out and more quickly support States and local officials in that capacity.

If a local area is overwhelmed—if they have systems overwhelmed, at that point, they might request FEMA assistance on a more traditional basis that you are used to. I would note the Stafford Act isn't really designed for this sort of situation, but they are analyses of that going on right now.

Mr. WALKER. Thank you. Madam Chair, I yield back.

Ms. UNDERWOOD. The Chair now recognizes for 5 minutes the gentlewoman from New Mexico, Ms. Torres Small.

Ms. TORRES SMALL. Thank you, Madam Chair. Thank you for being here. I want to pick up on that string of coordination with State and local governments because as you know State and local governments are at the front lines of this crisis right now.

Dr. Redd, it is my understanding that is the CDC's standard to notify State officials if individuals from their State were on-board a suspected coronavirus-infected ship. Can you confirm that?

Dr. REDD. I think that, that depends on the setting. I think that with the volume, we are working with the cruise industry to identify who would actually do that notification.

Ms. TORRES SMALL. In what setting would you not notify a State if there was a——

Dr. REDD. State. Yes. Yes, we would—well——

Ms. TORRES SMALL. Oh, perfect.

Dr. REDD. Yes.

Ms. TORRES SMALL. OK. Wonderful. Wonderful.

Dr. REDD. I think contacting the individual is just a different story.

Ms. TORRES SMALL. Fantastic. OK. I——

Dr. REDD. Misunderstood you.

Ms. TORRES SMALL. I appreciate that if the State—you will notify the State if they are. Today, we learned that 2 individuals from my district who were on a cruise ship with suspected cases tested positive for the coronavirus.

It is my understanding that the individuals returned to their local community for over week before the CDC notified the State of New Mexico. What are you doing to rectify this failure of communication?

Dr. REDD. Oh, I have to look into that particular instance. I am not familiar with that. We can get back with you on what the specifics of that.

Ms. TORRES SMALL. I appreciate that. I know things are moving incredibly quickly, and so I—we are all working to just move forward better together. So to that note, will the CDC commit to sending a list of all individuals who have traveled to New Mexico from areas of concern today?

Dr. REDD. I think that, that lists—I think this is one of the problems that we are coming into is that there is transmission from so many different places that it sort of depends on what—what the—what locations coming from would count as a place of concern.

So I think—you know, this is one of the things that we are working with is many countries in Europe now have cases. It is not just Northern Italy as it was a week or so ago. I think this is one of the things that was referenced earlier that there is daily discussion about what should be done about travel from locations just as you described?

I think our current policy is, is problematic in that people—there is a lot of cases and outbreaks being sparked from travelers. You have heard from the testimony this morning that Europe is the new China from the standpoint of coronavirus and exporting of cases.

Ms. TORRES SMALL. Thank you, Dr. Redd. Just to—I recognize that this is a big problem you are trying to get your handle around. So maybe we can identify some of the—the easier places to start in terms of State notification. Can you notify the State of all service members who are coming to New Mexico who have traveled from areas of concern?

Dr. REDD. I believe that, that notification is occurring——

Ms. TORRES SMALL. Let's confirm that.

Dr. REDD [continuing]. Particularly from—well, parts of the world that service members have been identified in. But let me—we will take that for action.

Ms. TORRES SMALL. That is fantastic. The same with DoD personnel?

Dr. REDD. Yes.

Ms. TORRES SMALL. OK. What about public health service corps members?

Dr. REDD. I think that, that is a reasonable suggestion. Let me though—I think this is one of the instances where the more places that have cases, we could essentially be identifying any traveler returning to the United States.

There is a point at which that ceases to be as useful as—particular as it was earlier when it was China or you could say China, Iran, South Korea, Italy.

Ms. TORRES SMALL. That is fair.

Dr. REDD. Because I think there is going to be a point where that notification really—it is harder to take that for public health action because there would be so many people everywhere. You could almost take a plan coming from Europe.

Ms. TORRES SMALL. Thank you, Dr. Redd. Just switching, quickly in my last minute, to date how many people have been tested for the coronavirus across the United States?

Mr. CUCCINELLI. So I can't give you an exact answer on that; 17,084 and have been tested at CDC. There are thousands that have been tested in the last week at State health department laboratories. We are working on setting up the system to collect information from the commercial manufacturers. So that——

Ms. TORRES SMALL. OK.

Mr. CUCCINELLI [continuing]. That what you are describing—the question that you are asking is the one that we are seeking to be able to answer.

Ms. TORRES SMALL. So 17,084 confirmed plus other places that you are working on seems lower than other countries where they are testing—South Korea, for example, can test up to 10,000 a day. Germany has done a lot. Do you have a time line for scaling up testing in the United States?

Mr. CUCCINELLI. Well, we have scaled up in the past week that there is 75,000 test kits for the—sorry—75,000 materials sufficient to test 75,000 people on the public health side, a million on the commercial side. I would like to say that we cannot really test our way out of this epidemic. That that is a part of the response, but there are many other——

Ms. TORRES SMALL. And it is——

Mr. CUCCINELLI [continuing]. Important elements.

Ms. TORRES SMALL. Absolutely. But it is a part we need to focus on. How many tests a day can we expect in the next few weeks?

Mr. CUCCINELLI. Yes, I think that—that is a hard question because there is a lot—all the other things besides having the materials are——

Ms. TORRES SMALL. Do you have a goal?

Mr. CUCCINELLI [continuing]. Appropriate? I think what we want is what everybody here wants which is every person that needs a test can get it the same day. That would be the objective.

Ms. TORRES SMALL. OK.

Mr. CUCCINELLI. We are working toward that end.

Ms. TORRES SMALL. Thank you. My time has expired.

Ms. UNDERWOOD. The Chair now recognizes for 5 minutes the gentleman from Pennsylvania, Mr. Joyce.

Mr. JOYCE. Thank you, Madam Chair. Thank you for holding this hearing. I would also like to thank both of our witnesses for appearing today and for keeping Congress informed as to what President Trump's administration and the efforts to combat and contain this novel coronavirus.

Secretary Cuccinelli, thank you for mentioning in your testimony the work that DHS is doing to keep our front-line employees safe, especially given that the nature of their work leads actually to a higher risk of exposure. You mentioned in your testimony that all CDP—all CBP personnel have access to personal protective equipment.

Can you assure us that there is sufficient equipment for all personnel at CBP? Do you believe additional funding is necessary to ensure the on-going availability of this protective equipment?

Mr. CUCCINELLI. Congressman, tracking PPE for our employees has been something we have done from Day 1, well back into January. We are comfortably ahead of that curve. We keep a stock of 30-plus days on hand. We would probably say we have around 45 days available. That is standard for us.

We are not seeing a threat to that. We are not seeing a drawdown at a pace that is cutting into our ability to maintain protection and protective gear for our employed work force.

Mr. JOYCE. Thank you, Mr. Secretary. On another matter, the lack of a full operational control of our Southern Border is something of particularly concern to many of my constituents.

Since taking office, President Trump has repeatedly asked for additional funding for the border security, including hard, physical wall infrastructure. That has either gone unfunded or ignored by Congress.

Briefly—Mr. Walker said this—but given the control that comes in and out of our Nation is at the hands of CBP, it is imperative that we seek to prevent this novel virus from coming in through our borders. Do you agree that fully funding the President's budget request for border security is necessary for the protection of our country?

Mr. CUCCINELLI. Well, certainly, we do, Congressman. The way you phrased it, border security, speaks to the comprehensive nature of the strategy we need to employ which includes the whole wall system, but it also includes our people, the folks in the Border Patrol and in ICE who back them up at USCIS who do much of

the processing. That entire system is necessary to maintain security at our border.

One of the things—you know, every month you all see the numbers of apprehensions and so forth. But what doesn't get talked about as much is what we call the getaways. There are plenty of people who are not caught.

When you think about that in terms of communicable disease that takes on a whole new threat. It has existed with other communicable diseases; measles to name one—TB. We do see them in—across the United States at levels that many communities haven't seen in some time because of the situation at the border.

We are not yet having a coronavirus problem at the Southern Border, but we are planning for such a problem as we see the case numbers in South and Central America rise precipitously as we are in other parts of the world.

Mr. JOYCE. Secretary Cuccinelli, you talk about individuals who are apprehended and those who get away. Have you apprehended individuals from China or other nations where we have known cases of the virus?

Mr. CUCCINELLI. We have not yet apprehended anyone crossing illegally—well, I will speak to legally in a second—who has tested positive for the coronavirus. We have apprehended almost 400 Chinese nationals since January 1—no positive coronavirus tests amongst those individuals or any others at this point.

We have also based on the 212(f) proclamation the President implemented on January 29—I should say 31, effective February 2. We have turned away people from all—many countries of the world because they had been in China or Iran in the previous 14 days.

The No. 1 category of foreign nationals we have turned away are Canadians. Chinese are second at our land ports of entry under the 212(f) authority. So we don't know who amongst those folks had what medical condition because they were turned away.

Mr. JOYCE. Thank you, Mr. Secretary for your attention to this subject. I yield my remaining time.

Ms. UNDERWOOD. Mr. Cuccinelli, I just wanted to follow up on that. Are you all testing every apprehended individual from an affected country?

Mr. CUCCINELLI. I am sorry. Are we—I am sorry, ma'am. I didn't hear you.

Ms. UNDERWOOD. Are you testing every individual apprehended from a coronavirus-affected country?

Mr. CUCCINELLI. No, we are not. No, we are not.

Ms. UNDERWOOD. OK. So you said that—you just said that there—out of the 400 Chinese nationals that there was no coronavirus found. So how many of those 400 were you testing?

Mr. CUCCINELLI. I don't know how many we have tested. We don't test unless observe symptoms again using already existing protocols. We are not creating yet new protocols to deal with potential coronavirus sufferers. We deal with them as we would any other immigrant that we encountered.

Of course setting this virus entirely aside—one of CBP's roles, though not medically trained, is to observe those coming into the country for symptoms of illness in general.

Ms. UNDERWOOD. Absolutely. Yes. We are very well aware of the screening standards—passed a bill to that end out of this committee. Would you be willing to submit to us in writing a summary of those tests that you—that CBP has performed on migrants apprehended at the Southern Border?

Mr. CUCCINELLI. I would be happy to go determine how many immigrants we have tested for coronavirus.

Ms. UNDERWOOD. And submit it to us in writing to this committee——

Mr. CUCCINELLI. Yes.

Ms. UNDERWOOD [continuing]. Promptly, please? Thank you, sir. The Chair will now recognize, Mr. Rose, from New York, for 5 minutes.

Mr. ROSE. Thank you, Madam Chairwoman. Dr. Redd, would you agree that we will not be able to test nearly enough people without automated, automatic or automated testing approved in our State laboratories?

Dr. REDD. I think that, that kind of testing is being done at the commercial scale. I am not sure it is necessary in the public health scale side. That is where these different roles that the two types of testing play is——

Mr. ROSE. So maybe I am confused about something. My understanding is, is that automated testing needs to be approved by the CDC in conjunction with the FDA before it can occur in any laboratory private or——

Dr. REDD. There is——

Mr. ROSE [continuing]. Commercial or public.

Dr. REDD. There is a process of emergency use authorization. That is an approval that the FDA grants to do a test that is earlier in development.

Mr. ROSE. You review it though?

Dr. REDD. Well, we develop it. We basically——

Mr. ROSE. So has any—it exponentially increases the number of tests that can be conducted in 1 day? It is significant. We need for it——

Dr. REDD. Right.

Mr. ROSE [continuing]. To happen as quickly as possible. You would agree with that?

Dr. REDD. Right. I think that is right. I think whether we do that on the commercial side or in the public health side is——

Mr. ROSE. I don't care what laboratory is doing it. It has got to happen.

Dr. REDD. Exactly.

Mr. ROSE. Has any laboratory in the country been approved for automated testing yet?

Dr. REDD. I am—I can check on that. I can tell you that the LabCorp and Quest use those kind of systems, and they have been approved.

Mr. ROSE. So is it happening anywhere in the country?

Dr. REDD. It is happening in those laboratories.

Mr. ROSE. OK. Because it is not——

Dr. REDD. Let me—let me verify that.

Mr. ROSE. That way—there is a difference between semi-automated. There is manual, semi, and then full automated. We have to get to fully automated, correct?

Dr. REDD. Let's check to—I will——

Mr. ROSE. Because I can tell you not one laboratory in New York has been approved. Can I have your word here publicly that you will make this a top priority to get not just in New York, but as many laboratories across the country approve for this as quickly as possible?

Dr. REDD. I think we want the same end which is to have really every person that needs to be tested be able to get that test done——

Mr. ROSE. Certainly.

Dr. REDD [continuing]. The day that they need it. To that end, I think the exact means that you use to get there—I wouldn't—I don't want to quibble about that.

Mr. ROSE. But you do agree we can't get there without automated testing?

Dr. REDD. Some level of automation, certainly.

Mr. ROSE. Some level. OK. So thank you for that. I look forward to working with you and your team——

Dr. REDD. Yes, sir.

Mr. ROSE [continuing]. To get New York there as quickly——

Dr. REDD. I——

Mr. ROSE [continuing]. As possible.

Dr. REDD. It is a high priority. I think what is going on there is something that we are working very closely with the health department on.

Mr. ROSE. Do you have any sense of a time line for how quickly we can get to these automated testings approved in New York?

Dr. REDD. Well, I think—I guess again I think that this is not a problem we can test our way out of. I think that, that is part of the overall strategy. We need to be testing so that our—we understand where we need to be intervening, and we understand the effectiveness of those interventions. So I actually——

Mr. ROSE. Of course.

Dr. REDD. I don't think every—for public health purposes, every single person doesn't need to be tested; for example, in the influenza pandemic 10 years ago, we weren't able to test everyone. We didn't need to test everyone. Our public health interventions were guided by the ability to extrapolate from the laboratory tests that we had.

Mr. ROSE. Of course.

Dr. REDD. Different clinical purposes.

Mr. ROSE. Absolutely. Those who have symptoms though. Those who are symptomatic should be able to be tested same day? We can't do that without these testings. It is necessary.

Dr. REDD. Especially——

Mr. ROSE. It is not sufficient.

Dr. REDD. Right, and but especially for clinical purposes. The public health—you know, doing a representative sample doesn't help you if you are the patient——

Mr. ROSE. Absolutely. So my apologies in advance that we are going to be contacting your office every single day until this happens in New York——

Dr. REDD. You don't need to apologize.

Mr. ROSE [continuing]. And across the country. Mr. Cuccinelli, thank you. Thank you for your service. I want to talk to you about foreign travel. It is my understanding that those foreign nationals traveling from China and Iran are now tested upon reaching a domestic airport; is that correct?

Mr. CUCCINELLI. No, that is not correct. They are barred from entering the United States.

Mr. ROSE. OK. So in terms of foreign screenings though, where—which nations are we doing screening at——

Mr. CUCCINELLI. So the way it works is the 212(f) only covers foreign nationals. The President doesn't have the authority——

Mr. ROSE. Mm-hmm.

Mr. CUCCINELLI [continuing]. Under 212(f) to do anything to you and I as United States citizens. So U.S. citizens, legal permanent residents, and their families come in. Those are the people being screened at the airports.

So an American citizen flies from China—and there are still some flights—to one of the 11 airports. They encounter a CBP OFO officer, the blue uniform folks you see when you come from another country. You show them your passport.

Now, they are going to see you came from China. They are going to send you to secondary screening. That screening is run by CWMD, our contract medical personnel. Unlike the traveling questions that CBP asks you, they are going to ask you medical questions. These are medically-trained personnel.

Mr. ROSE. This is upon entry to the United States?

Mr. CUCCINELLI. Correct. At the first point of——

Mr. ROSE. Is there any consideration of expanding that to other nations that are hard-hit by this; Italy, for example?

Mr. CUCCINELLI. Yes. There is regular consideration of that.

Mr. ROSE. OK. Do you think that is a good idea at this—knowing what we know right now to expand that to South Korea, Italy?

Mr. CUCCINELLI. Well, in the particular cases of South Korea and Italy, those allied nations took very quick affirmative steps to start performing exit screening. They are essentially doing on exit what our medical screeners would do on entry.

They did that in part to avoid being swept into a 212(f) situation. That was acceptable to the President's task force. He accepted it because of their transparency. These are allied nations who are being very up-front with us about what they are receiving.

Mr. ROSE. From who?

Mr. CUCCINELLI. They are also barring passengers who for instance test over 37 and a half degrees centigrade for a temperature, just to use an easy one.

Mr. ROSE. Well, what I will ask is that please keep us posted on your analysis going forward as to whether that should be expanded.

Mr. CUCCINELLI. Glad to do so.

Mr. ROSE. Thank you.

Ms. UNDERWOOD. Oh, yes, I am going to wait for him to sit down. OK. The Chair now recognizes Mr. Bishop for 5 minutes.

Mr. BISHOP. Thank you, Madam Chairman. I have had to step out for a bit so you all may have covered some of these items. But Dr. Redd, do I still understand that it is the objective—the Vice President said that he was—they were trying to make it so—the administration is trying to make it so that any doctor could order a test; is that correct?

Dr. REDD. Yes, sir.

Mr. BISHOP. I heard you recite the numbers that I was hearing last week that there would be a million test kits sent out by the end of that week. Did that in fact occur?

Dr. REDD. It did. That is from the commercial side, not the public health side; 75,000 was——

Mr. BISHOP. Right.

Dr. REDD [continuing]. The number from the public health side.

Mr. BISHOP. Understood that. Do you get feedback to indicate that there are uncertainties on the part of doctors at this point in time whether or not they can order tests?

Dr. REDD. There are not uncertainties that I have heard.

Mr. BISHOP. Word is that schools and universities are closing. North Carolina has several. Is the CDC recommending pulling classes until the virus is more contained or slows?

Dr. REDD. So that is a local decision. We have been working with communities that have substantial human-to-human community transmission. It is really a case-by-case basis depending on the—you know, basically what the issue is, what set of activities need to be changed from the normal way.

We have actually posted guidance today for King County and Santa Clara County as examples of how to adapt our more general recommendations to particular communities. But we are working—I don't know the details of how we are working with the communities in North Carolina, but we would be working minute-to-minute with them on sort-of side trading these recommendations to be the right intensity.

Mr. BISHOP. In response to the Vice Chairman's questions early on about how many persons you expect to be infected and so forth, you said it depends on the intensity of the—of our public health response.

How are you—I mean—so are there questions about how intense to make it? I mean you all—you are part of the organization that decides how intense of the response to have.

So are you holding back or have you decided what an ideal is? Or is that changing day-to-day based on circumstances. If it is changing based on circumstances, I would assume that would be test results indicating how wide-spread this is?

Dr. REDD. So I think that the—as communities identify cases in their community, there are a set of activities that—there are questions, you know, should we cancel this event? Should we cancel that? That—those aren't the kind of things we can have a Federal guidance that would cover every eventuality.

So it is—you know, I think this is an instance where it is a wide-spread event. The Federal Government can't cover every location. So our role is to support State and local health departments.

There are going to be some instances where we can provide boots on the ground, but in general we are going to be providing guidance and working with communities to make their decisions based on their own circumstances.

Just for example, a large gathering—if it is people that are at high risk, so older people or people with chronic medical conditions, if that kind of thing is known it would—a large gathering would be a smaller gathering than if it were teenagers.

Mr. BISHOP. Yes, sir. Thank you.

Mr. CUCCINELLI. Congressman, could I add——

Mr. BISHOP. Yes, sir.

Mr. CUCCINELLI [continuing]. A little flavor to that as a former State attorney general?

Mr. BISHOP. Yes, sir.

Mr. CUCCINELLI. For each of you, you all represent many different States. Your States have in many cases vast authority—legal authority in this arena. It is easy for us in the Federal Government to overlook that, but your Governors and your public health professionals have tremendous authority in this area.

Many Governors, of course, have declared public health emergencies and so forth. I have talked to a number of AGs—many Governors—we have both talked to hundreds of local and State officials. That is something that is—that allows for the very specific surgical application of authority place to place, State to State.

Mr. BISHOP. Point well taken. Thank you, sir. Has your question today covered the fact that we have a no-ban vote tomorrow on the section 212(f) authority?

Mr. CUCCINELLI. No, sir.

Mr. BISHOP. Well, let me ask you quickly. Then we are voting tomorrow on this political no-ban act to restrict the President's use of 212(f) authority. Didn't the President use 212(f) authority here in order to have an early intervention to stop Chinese folks—nationals—from coming in, in a way that has helped the response to the——

Mr. CUCCINELLI. That is exactly what he used. It was available to use quickly at the advice of the task force. It has been effective.

Mr. BISHOP. Would it have been a problem if that authority had been limited or restrained?

Mr. CUCCINELLI. There is no question that the use of that authority has bought us time. You have heard from both Dr. Redd and I various ways that we have used that time in the Federal Government. Our partners in local and State government have used that time to be better prepared as this virus advances.

Mr. BISHOP. Thank you, Mr. Cuccinelli. Thank you, Dr. Redd. I yield back.

Ms. UNDERWOOD. The Chair now recognizes Ms. Slotkin for 5 minutes.

Ms. SLOTKIN. Thanks, gentlemen. I just want to say at the outset that I am really invested in your success. I think that we heard from the former head of the CDC who served, I think under the George Bush administration, who talked about the importance of trust and how critical that is in a public health crisis or moment.

So I really want you to succeed. I want all of us succeed. We are all on this boat together. So I really want to have clarity for the

people who are at home who are looking to you all and to us for guidance. I guess I have the question on preparedness.

I think we have heard a couple of times from you, Admiral Redd, that the earlier we intervene the fewer number of cases and the lesser the spread for lack of a better term.

I have seen other countries take much more aggressive steps. You know, Italy is now—obviously, has a lot more cases, but they have banned travel. People are staying in their homes. There is no going to tourist destinations. There is no public gatherings.

Should there be anything else and guidance that we give beyond public health, washing your hands, staying—giving a social distance? Should we be telling our businesses to go to telework if at all possible?

Should we be getting people out of offices and schools, not because this is such a terrible threat? I don't want to incite—I am not—I am just saying preparedness helps us blunt, you know, unnecessary panic.

Dr. REDD. Preparedness does help. I would point to Singapore and Hong Kong as examples of aggressive early action that has blunted the epidemic.

Ms. SLOTKIN. So——

Dr. REDD. I think in the case of Italy, it may be a lot too late.

Ms. SLOTKIN. It got away from them. So what are the 2 or 3 other things that people should be doing besides the public health guidance to minimize the spread of this illness, since Michigan we just got our first 2 cases yesterday?

Dr. REDD. So I think that the—there are some individual actions and there are community actions. I think that all of these—protecting the elderly and medically vulnerable is the highest priority because those are the people that are going to have the worst outcomes.

So I think there is a lot of work around nursing homes in particular that needs to be undertaken to prevent the virus from getting into the nursing homes—things like reducing the number of visitors.

Ms. SLOTKIN. Mm-hmm.

Dr. REDD. If anybody is sick—working there, being absolutely certain that, that person doesn't—isn't allowed back in. That people who work in one nursing home, don't work in another nursing home.

Ms. SLOTKIN. Mm-hmm.

Dr. REDD. That when a patient is transferred from a nursing home to a hospital, they are not sent to another nursing home.

Ms. SLOTKIN. OK.

Dr. REDD. These are the kind of things that are known to spread other kinds of infections in that setting. I think that the work that we do to protect people in nursing homes and the elderly is critical——

Ms. SLOTKIN. So can I ask a quick question because again on the public trust issue—the issue of testing. So I will tell you that the sense in the public is that there is not enough tests.

I am glad to hear the numbers that you all offered that there is 75,000 public health tests and another million available commer-

cially. We are not getting those to our States in a way that feels reassuring to people.

I guess I am confused on why we are playing catch-up on this. My understanding is we have tested 8,500 people across the country, but that South Korea is capable of testing 10,000 people a day. Can you help me understand why they are able to do that?

Dr. REDD. They have implemented a different system then the one that we are using. I am—I think that we probably should be scoring ourselves on the ultimate impact of the epidemic and how well we control it. Testing is a part of that. It is not the only part.

So I am not sure—I mean we don't have really good visibility on who is being tested. If you are just testing people who are perfectly well, have not had any exposure, have a negative test, I am not sure that really contributes to the public health outcome.

Ms. SLOTKIN. OK.

Dr. REDD. I do think that—I agree with what you are saying that there is a sense that we haven't done enough in testing. We are doing everything we can to correct that. I also agree with your statement about the importance of trust.

Ms. SLOTKIN. So I just—I am sorry. I just have one quick second. So a lot of us really do respect the head of the NIAID, Mr. Fauci—Dr. Fauci. He has gotten us through a lot of crises. I guess I would ask that while you have devolved a lot of things to the States—and I understand things are going to be certainly a little bit different.

I guess I am just a prisoner to the fact that I was on—in New York City on 9/11. Whatever people think of Rudy Giuliani, he was clear. He was available. He was telling us what was good and what was not good.

I am telling you that people are missing that. They are feeling like they want clearer guidance. Just my strongest recommendation is that Dr. Fauci be allowed to take that role to reassure the country.

Ms. UNDERWOOD. The Chair now recognizes Mr. Crenshaw for 5 minutes.

Mr. CRENSHAW. Thank you, Madam Chairwoman. Thank you both for being here. I will actually continue along that line of questioning because I have similar questions about, you know, what is the standard we are trying to achieve with testing?

We do hear that South Koreans are testing huge amounts of people, and it—it makes people feel like they should also have a test whenever they want. Now, of course, you have to buttress that against the reality that we come up against which is, you know, are we then excluding people who actually need the test.

So I do want to get a more detailed sense from you of where we should be. What is the right realistic standard that we should be trying to achieve with respect to testing and availability of testing? Should the threshold be lower than it currently is because right now I believe you need doctor's orders to get a test?

Dr. REDD. So I—this is a really important question. I think right now there is this sense that you should just be able to get it. You know, anybody should get a test everyday if they want. I don't think that is really helpful to the response.

I think that in communities that have transmission it is very important to do enough testing to understand the epidemiology of the

disease. That is something that is a health department role so that kind of testing is critical.

There is some questions about just the kinds of things that, that kind of testing could help us understand whether schools are an important place for virus transmission. Children don't get as sick as older people.

Mr. CRENSHAW. Right.

Dr. REDD. We are not really certain if school closure is the right move. So we can't——

Mr. CRENSHAW. And I——

Dr. REDD [continuing]. Understand that without testing.

Mr. CRENSHAW. I agree with that general philosophy. So you have laid out the philosophy of standardizing testing. So I mean the next question is should we be reaching for a different standard than we are currently implementing or should we keep it about the same?

Dr. REDD. I think that a clinician saying this is a person that needs a test—and that can be a pretty low threshold. I think that is the right threshold action.

Mr. CRENSHAW. So the right threshold. Admiral Redd, you were also incident commander for the H1N1 pandemic response in 2009. Can you tell me what major differences there have been between the current response to coronavirus and the H1N1 a decade ago?

Dr. REDD. Yes. Well, I think the two biggest things are we had a drug that worked against the virus, and we were able to produce a vaccine within time to blunt the outbreak or at least to have it available during the peak of transmission.

I think the other—we knew more about flu then we know about this virus. Some of the issues that have come up about when people can transmit the virus are—wouldn't have fit conventional wisdom.

Mr. CRENSHAW. Mm-hmm.

Dr. REDD. So I think there is more that the scientific community has to learn about this coronavirus even though we—a lot of uncertainty in H1N1——

Mr. CRENSHAW. Sure.

Dr. REDD [continuing]. But less——

Mr. CRENSHAW. That goes without saying. I mean—but the actual response has it been dramatically different?

Dr. REDD. It is—it is a much larger response then we had for H1N1. I think there are more sectors of Government involved. We didn't do a lot of the things that we are doing now because they weren't appropriate, the border issues. We had cases here that the pandemic was first recognized in the United States. So that——

Mr. CRENSHAW. Right.

Dr. REDD [continuing]. That is a totally different situation.

Mr. CRENSHAW. Speaking of border issues, Mr. Cuccinelli, in the face of a global pandemic should we have less security at the border or more security at the border?

Mr. CUCCINELLI. Under those circumstances, more of course. I mean the greater your operational control of the border, A, the less incentive there is to attempt to pass through that; and B, this is just a numbers game—the less chance you then have of people who may not even know——

Mr. CRENSHAW. Right.

Mr. CUCCINELLI [continuing]. That they are infected because to Dr. Redd's comment about things that are different from H1N1, one—the biggest one for this non-medical person is asymptomatic transmission. That presents dangers that you can't even understand when they are right in front of you.

Mr. CRENSHAW. Do things like physical barriers, additional technology, and more personnel increase our border security?

Mr. CUCCINELLI. Absolutely.

Mr. CRENSHAW. I want to ask you both about our medical supply chain and how reliant we appear to be on China for some very basic things, like generics, antibiotics, things like that.

Could you both discuss the current state of our medical supply chain, specifically how the Chinese shutdown has affected it and how we can get better? How can we become more self-reliant in the face of future pandemics?

Dr. REDD. It is an important question. That—unfortunately for—to be able to answer your question directly and the department that area is handled by the assistant secretary for preparedness and response.

Mr. CUCCINELLI. So I have been of course part of the President's task force since January. This has been a focus for us.

I would note, Congressman, that if you go back and look at things like that first 212(f) proclamation, you will see—and how we unrolled it—you will see that we made accounting—we accounted for economic activity, not because of the money, but because of the supply chains to which you are referring—and not just medical.

We—at FEMA, for instance, and CISA, we keep track of 7 different sectors. Health care is just one of them—transportation, energy, others. Because of the interconnectedness of our economies and societies around the world, we thought it very important to keep that cargo flowing both by air and sea. We have made accommodations to do that.

I think that a lot of people's eyes, not just in Congress but in the Federal—but in the Executive branch as well, have been opened to some of the nuances of the supply chain reliance. My understanding—and I am not the expert, but I am here, and you want your questions answered.

My understanding is that we are not in danger on any particular drugs with respect to interruptions from China at the moment, not in any significant way—that there is substantial—I will call them stockpiles, but they are working capital equipment of drugs. There are substitutes that fill the needs for where we do have gaps. That gets us out of months and months——

Mr. CRENSHAW. Mm-hmm.

Mr. CUCCINELLI [continuing]. But it—when this is over and we all step back and ask ourselves what did we learn here, this is definitely going to be one of the subjects we are all going to want to come back to and sit down together. As Congresswoman Slotkin noted and as Vice President has said, we are all in this together. Well, if history is any guide, we will be in it together some time in the future so——

Mr. CRENSHAW. Thank you, Madam Chairwoman.

Ms. UNDERWOOD. Thank you. The Chair now recognizes Mrs. Watson Coleman for 5 minutes.

Mrs. WATSON COLEMAN. Thank you very much. Dr. Redd, one of the functions of the CDC is to collect information of what is happening to our communities across the country.

I know that the CDC is no longer depending upon the State test to come to you to be confirmed before they can move forward with the decisions they have to make, but are you all doing anything to collect all the information so that there is essential place where the information can be held? Are you disseminating it?

Dr. REDD. We are collecting information from the States. The status of the tests that the States are doing, they are performing the diagnostic tests. They are then actually sending the clinical specimen to CDC for verification.

Mrs. WATSON COLEMAN. That is not what I am asking you. Because the CDC director said yesterday that you are not—we are not depending upon their sending it to the CDC for verification now. You are going to—I believe what found——

Dr. REDD. Well——

Mrs. WATSON COLEMAN [continuing]. In the States or what I am told.

Dr. REDD. There is this designation called presumptive tests.

Mrs. WATSON COLEMAN. Yes.

Dr. REDD. We are encouraging them to take action on those results. Yes.

Mrs. WATSON COLEMAN. What I am really wanting to know is are you collecting the information—is there going to be essential point of collecting the information? Because the one thing—and Ms. Slotkin kind-of referred to it.

We don't know the extent of what is happening in our communities. We experience an incident daily. So it becomes a new phenomenon. So we would like to kind-of have greater expectation then we have now. We don't have that sense of confidence coming from the CDC or from the White House.

Dr. REDD. Let me describe it in a little more detail what we are doing because we are collecting the results of test that are being done at States. The other thing that we are doing is working with our system for influenza where we are testing specimens that are being collected with people that have respiratory illness in Santa Clara County, San Francisco——

Mrs. WATSON COLEMAN. Are you——

Dr. REDD [continuing]. San Diego——

Mrs. WATSON COLEMAN. Are you also collecting the number of presumptive cases? Are you collecting the data that the States are finding that X number of cases—New Jersey has got what—I don't—I don't even know today. It is more than it was yesterday.

Dr. REDD. We are.

Mrs. WATSON COLEMAN. Are you collecting that information?

Dr. REDD. We are.

Mrs. WATSON COLEMAN. OK. Thank you. Thank you. This is a question—the CDC has reported that more than 600 confirmed presumptive cases. So we are all concerned that everyone is given the kind of screening, testing, and whatever treatment you can get irrespective of who you are.

So this question has to do the—a conversation that has been developing around this immigration enforcement free zones. So Mr.

Cuccinelli, I guess for you more than anyone, I know many health experts and legal experts are saying how important it is for these people to be able to go in and be tested and not fear being exposed to immigration enforcement. Have you all had that discussion at all in your——

Mr. CUCCINELLI. Yes.

Mrs. WATSON COLEMAN [continuing]. Whatever it is you have.

Mr. CUCCINELLI. Yes, we have. And——

Mrs. WATSON COLEMAN. Where are you on that?

Mr. CUCCINELLI. ICE has a pre-existing policy—and I mean pre-existing the virus where they don't do enforcement in health care facilities, doctor's offices, except under unique single case circumstances. So that is not an issue with respect to virus testing and anything of that nature.

Mrs. WATSON COLEMAN. So those individuals don't have to fear——

Mr. CUCCINELLI. We repeated that publicly.

Mrs. WATSON COLEMAN [continuing]. Going—those individuals don't have to fear trying to get tested or treated or whatever?

Mr. CUCCINELLI. Correct.

Mrs. WATSON COLEMAN. OK. All righty. Mr. Cuccinelli, the President has touted that measures the administration took to try to prevent the infection from coming into the country by screening certain passengers coming in.

We are told that there have been more than 40,000 people who have been screened, but only 1 of those passengers has actually been confirmed positive with the COVID–19. Meanwhile, 2 of the people conducting the screening—they work for you—have tested positive in addition to 3 TSA—TSOs.

Can you tell me if you think these screenings are effective and if you think that this is where we should be applying our priority resources? If so——

Mr. CUCCINELLI. So——

Mrs. WATSON COLEMAN [continuing]. Why?

Mr. CUCCINELLI. So obviously, this screening is at the 11 funneling airports that you are referencing. My most recent data is consistent with your comment about 1 person being quarantined; although, over 30,000—over 34,000 have been asked to do self-isolation and then communicate with their local public health authorities.

We don't know—we don't go back to those to find out how many ultimately became positive. Again, this goes back to the asymptomatic problem of people coming through screening. They won't necessarily show symptoms.

Mrs. WATSON COLEMAN. Well, you know, having information come back, having information collected, having information in a central location, and having information available is something that is very important. There seems to be a big gap in that in what we are experiencing right now. That is very troubling and concerning.

My last question, today Governor Inslee just banned gatherings of 250 or more in Washington State and Governor Cuomo yesterday ordered a 1-mile containment around New Rochelle.

As Federal leaders charged with responding to this virus, can you tell the committee whether you had any direct involvement in the decisions that these Governors have made to try and contain the virus, either one of you? Is that yes or no?

Mr. CUCCINELLI. Yes, I certainly can't speak to having personal involvement, but both States have been in deep conversations with their Federal partners: DHS, CDC, and so forth for some time now.

Mrs. WATSON COLEMAN. OK. Thank you. I yield back.

Ms. UNDERWOOD. The Chair now recognizes the gentleman from New Jersey, Mr. Van Drew, for 5 minutes.

Mr. VAN DREW. Thank you. Thank you for not retiring. Thank you both for being here. So I just want to clarify a few things in my mind which I think maybe would help everybody and sort-of almost a little bit rapid-fire. But we go back to border security. I just want to make sure this is clear to people because I think it is clear in common sense to me.

If we have open borders, if we have sanctuary cities, sanctuary States, if we have people traveling around that just got into the country not in the normal route, is it your feeling, Mr. Cuccinelli that, that eventually could increase the risk without question of these types of diseases?

Mr. CUCCINELLI. Oh, well certainly. Absolutely. That is a simple matter of math.

Mr. VAN DREW. I mean there is nothing complicated about this. If people for lack of a better term sneak into the country and haven't gone through the normal legal immigration route, we have a larger chance of the disease spreading more; is that correct?

Mr. CUCCINELLI. Yes. The legal route, we have an immediate screening for illness that is part of the legal requirement for entry.

Mr. VAN DREW. OK. The second question that I have is about the travel restriction that was originally criticized when the President put the travel restriction on China and was seen as something abhorrent and terrible.

If you were to look back now, would you say, Dr. Redd—both of you that, that was obviously as much as we have issues and problems now—the issues and problems and challenges would have even been deeper and greater; is that correct?

Mr. CUCCINELLI. Well, our understanding at the time when we recommended it to the President and when we had that discussion with him was that the academic models suggested not to do that.

So our advice was contrary to the then-existing models as it was described in the task force. We made the recommendation anyways. The President was well aware of that sort-of contraindication. He adopted the recommendation. We universally now believe we benefited tremendously.

Mr. VAN DREW. Of adopting——

Mr. CUCCINELLI. Obviously, it was fortunate from adopting those measures.

Mr. VAN DREW. OK. In canceling large events that we spoke about, wouldn't it be dependent upon the State to—I mean just thinking about how large the United States of America is compared not to China obviously, but to a place like Italy or some other areas?

Wouldn't it be on an individual case-by-case situation too whereas for example I understand in Washington where you might want to cancel any large gathering where in Nebraska perhaps you would not? Is that accurate at this point? Is that——

Mr. CUCCINELLI. It most——

Mr. VAN DREW [continuing]. How we would deal with that?

Mr. CUCCINELLI [continuing]. Certainly is. It is why it is appropriate for Governor Inslee to make that decision. It is why it is appropriate for Governor Cuomo to make those decisions and not for us sitting here in Washington to impose those decisions. That is part of the partnership.

The guidance you have heard Dr. Redd talk about has been flowing freely. It has changed because this virus has literally not been known in human beings for 3 months on the planet earth yet.

So we are still learning, and we are going to be learning for months to come. But that is why those local sensitivities and letting local authorities have final say is so important.

Mr. VAN DREW. Let me understand testing for a second. So, you know, hypothetically I don't feel well. I feel that possibly I have the coronavirus. I call my doctor, my nurse practitioner, whoever the appropriate health professional is. I say I really don't feel good. I have the symptoms. What should I do?

They are—that person right now as of today is going to be able to get that test if their doctor or health professional thinks that is appropriate; is that correct?

Dr. REDD. It is. I think there is some work to be done to make sure that they can get it as quickly and as easily as it needs to be.

So I think that the test is available but making that patient experience optimal, there is still work to be done so that it gets done, same day. It gets a result back quickly. There is work to be done there even though it is available.

Mr. VAN DREW. Are we getting close to where it would be the same day?

Dr. REDD. I think we are getting closer, but I wouldn't want to give you a time line that by X date it is going to be perfect.

Mr. VAN DREW. OK. Another question too. We all understand older people are at risk, immunocompromised are at risk. A thought that came to me—and I think I know the answer, but pregnant women and their unborn child that hasn't been born yet.

Dr. REDD. Yes, I think right now the evidence isn't in. There—the evidence that there is does not suggest that, that is a group that is at particular risk, which is a little bit surprising. But that is the state of science——

Mr. VAN DREW. Thank God.

Dr. REDD [continuing]. Today.

Mr. VAN DREW. Yes. Israeli researchers have been saying that they are months away from developing a coronavirus vaccine. Any thought on that?

Dr. REDD. I generally go with Dr. Fauci's talking points on this. There will be a vaccine available pretty soon, but it won't be tested yet. That is really the time-consuming thing.

So I don't—I am actually not sure what the Israelis are promising, but having a vaccine available doesn't mean that it has been shown to be safe and effective. That is what takes a substantial

amount of time. There are 2 cycles of test that need to be done so it is going to be while before we have it—a vaccine that is approved that we know is safe and effective.

Mr. VAN DREW. OK.

Ms. UNDERWOOD. The gentleman's time——

Mr. VAN DREW. It——

Ms. UNDERWOOD [continuing]. Has expired.

Mr. VAN DREW. Did I go over? OK. I am sorry. Thank you.

Ms. UNDERWOOD. OK. Thank you. The Chair now recognizes the gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. I thank the Chair very much and the Chairman and as well the Ranking Member. I ask unanimous consent to place in the record the American Academy of Family Physicians letter March 11 and a letter from me on February on February 26. I ask unanimous consent.

Ms. UNDERWOOD. Without objection.

[The information referred to follows:]

LETTER SUBMITTED BY HON. SHEILA JACKSON LEE

February 26, 2020.

The Honorable BENNIE THOMPSON,
Chair, Committee on Homeland Security, 176 Ford House Office Building H–217, Washington, DC 20515.

The Honorable MIKE ROGERS,
Ranking Member, Committee on Homeland Security, Ford House Office Building, Washington, DC 20515.

RE: Preparedness of the Department of Homeland Security for a Coronavirus Pandemic arriving in the United States

DEAR CHAIRMAN THOMPSON AND RANKING MEMBER ROGERS: I write to express my concern that the Department of Homeland Security (DHS) may not be prepared for a major test of its preparedness for an eminent biological threat in the form of a global pandemic caused by the new coronavirus designated as COVID–19. For this reason, I request an emergency briefing by the Acting Secretary of Homeland Security on our Nation's preparedness for a pandemic. Due to the unprecedented number of vacancies and acting positions in the agency as well as the high turnover throughout the department, the ability of DHS to meet an essential responsibility of protecting the Nation from a biological threat should be assured.

Today, Europe announced it has begun to prepare for a pandemic. It my belief that it is time for the United States to do the same. It is better for our nation to prepare and not have a pandemic occur, than not to prepare and it happens. Unfortunately, the disease is proving to be highly contagious, mobile, and has a mortality rate that is much higher than the flu, making it a significant threat to global health and to our Nation.

The National Infrastructure Protection Plan is the foundational document guiding the work of DHS in the event of a national emergency. The National Infrastructure Protection Plan already defines public health departments as critical infrastructure. This makes local and State public health agencies eligible to receive homeland security grant funds. The Federal Government's critical infrastructure protection efforts, and related documentation can be found at (*https://www.cisa.gov/national-infrastructure-protection-plan.).*

Thank you for accommodating this urgent request to convene a meeting with the Acting Secretary and head of FEMA to discuss our nation's preparedness for a pandemic and to determine what level of Federal funding will be needed to carry out necessary work to prepare the Nation for a possible pandemic. If you have questions, or need additional information, do not hesitate to contact my Policy Director, Lillie Coney at lillie.coney@mail.house.gov, [.]

Very truly yours,

SHEILA JACKSON LEE,
Member of Congress.

LETTER SUBMITTED BY HON. SHEILA JACKSON LEE

March 11, 2020.

The Honorable MITCH MCCONNELL,
Majority Leader, U.S. Senate, Washington, DC 20510.
The Honorable CHUCK SCHUMER,
Minority Leader, U.S. Senate, Washington, DC 20510.
The Honorable NANCY PELOSI,
Speaker, U.S. House of Representatives, Washington, DC 20510.
The Honorable KEVIN MCCARTHY,
Minority Leader, U.S. House of Representatives, Washington, DC 20510.

DEAR MAJORITY LEADER MCCONNELL, MINORITY LEADER SCHUMER, SPEAKER PELOSI, & MINORITY LEADER MCCARTHY: The American Academy of Family Physicians, representing 134,600 family physicians across the country, are working diligently to screen, diagnose, counsel, and treat patients who have or believe they have COVID–19. Our members are fully committed to helping their patients and their communities in this time of national need, but we urgently need greater coordination.

We urge Congress to contact the White House Coronavirus Task Force to ensure that information, supplies, and resources are flowing to physicians on the front lines, not just hospitals and public health departments.

Consistency and coordination will be the key to successfully responding to this public health crisis. We are doing all we can to assemble and disseminate information prepared by the Centers for Disease Control and Prevention and the World Health Organization to our members; however, we still lack critical information including:

- the availability of testing kits
- clearly stated protocols for when and how testing should be conducted
- how to address the scarcity of personal protective equipment (PPE) for frontline clinicians
- coordinated communication between Federal agencies, health departments, and the medical community.

This lack of information and communication will have a devastating impact on our efforts to treat our patients effectively.

If we are to be successful, it will be imperative that there is an enhanced level of collaboration and cooperation with the Federal Government and its agencies. We urge you to ask the White House Coronavirus Task Force to partner with family physicians and other primary care clinicians to ensure greater coordination and information sharing. Please contact Stephanie Quinn, Director of Government Relations for additional information.

JOHN CULLEN, MD
Board Chair, STRONG MEDICINE FOR AMERICA.

Ms. JACKSON LEE. Let me thank both of the witnesses. Very quickly, I have little time. Doctor Redd, let me thank you for your years of services. Can I find out the first moment that this country detected the coronavirus was coming in this direction?

Dr. REDD. It was in late January, I believe. I can get the date for you, but it was——

Ms. JACKSON LEE. But wasn't cases arising in China in 2019?

Dr. REDD. We believe that there were. The report that they produced was right at the end of December. We think that probably the first cases were sometime in November, detected at some point after that. We think actually the——

Ms. JACKSON LEE. So let me respect what is being done. Let me publicly say that I believe that this Nation was not prepared equating to its greatness and the responsibility it has not only to 300 million plus, but the world watches us. You are with the CDC. We needed to be far better prepared.

So this first thing I want to have is as Members spread out to their districts, we need an 800 number because we cannot use

coronavirus.gov and anything else. As Members, I have got people calling me and asking, are we closing their schools?

So I am asking both the deputy secretary convey to this task force, set up a number for Members of Congress, however, you want to have a Classified or a cold—give us a number to call. Can I have that conveyed and established, please?

Dr. REDD. I think we can commit to getting you a number that you are going to get an answer to.

Ms. JACKSON LEE. I appreciate——

Dr. REDD. I think——

Ms. JACKSON LEE. Thank you, Doctor.

Dr. REDD. I think that the—the question of whether a particular school is closing or not is not something——

Ms. JACKSON LEE. No, no.

Dr. REDD [continuing]. We would be able to answer.

Ms. JACKSON LEE. I am just saying these are the kind of calls that are coming in. Let me move on. The level of contagiousness of the coronavirus, would you explain that very briefly how contagious it is?

Dr. REDD. Sure. The measure that is used to describe that characteristic of a virus is the number of additional cases that would arise from one case. It is called the R naught.

Ms. JACKSON LEE. I am sorry. I am going to have to ask you to move quickly on that.

Dr. REDD. OK.

Ms. JACKSON LEE. Yes.

Dr. REDD. For influenza, it is 1.5. For this virus, probably somewhere between 2 and 3. So it is more——

Ms. JACKSON LEE. OK.

Dr. REDD [continuing]. Contagious than influenza.

Ms. JACKSON LEE. It is more contagious—this is the kind of information that really needs to be presented to the public, not out of panic, but in terms of educating them. Let me go to the test kits. You indicated that there was 75,000 to be tested. Is that test kits or tests?

Dr. REDD. Those are tests.

Ms. JACKSON LEE. Tests.

Dr. REDD. I agree that the——

Ms. JACKSON LEE. Yes.

Dr. REDD. This nomenclature of kit has been confusing.

Ms. JACKSON LEE. Right. So these are individual tests, 75,000?

Dr. REDD. Correct.

Ms. JACKSON LEE. Is the 1 million individual tests as well or kits?

Dr. REDD. That is people.

Ms. JACKSON LEE. People. So 1 million people possibility, but not yet?

Dr. REDD. It has been sent out. I think that availability depends on other factors than the tests materials itself. That is really the logistics of——

Ms. JACKSON LEE. But they are going out to labs and local governments? Are they going to physicians and hospitals?

Dr. REDD. They are—these are the laboratories companies that do these tests so——

Ms. JACKSON LEE. Right. So you have to access that?

Dr. REDD. Correct.

Ms. JACKSON LEE. There is a process to be tested. People need to be trained on how you use a test?

Dr. REDD. So there are people in the laboratory that are trained. There is—it is mainly protecting yourself if you are an individual collecting a specimen.

Ms. JACKSON LEE. I have got to go quickly. I thank you. So it is not standing out on the street and get tested or walk into an urgent care and possibly get tested?

Dr. REDD. In the United States, no. In Korea, they have drive-thru testing——

Ms. JACKSON LEE. I——

Dr. REDD [continuing]. Where you get tested in your car.

Ms. JACKSON LEE. That is coming to my next point which is I hope to get in a phone call back if I could. Low-income people, poor people do not have medical providers. They are walking into urgent care, clinics, or hospitals. You have got to be able to respond. I am not going to take the answer right now. You have got to be able to respond to that.

I do need a one-on-one conversation. Baylor College of Medicine, the infectious disease has a vaccine with 20,000 vials. They don't have the resources to do the clinical tests. I want them to be connected to the task force to get those clinical tests or to get them connected for resources.

They are ready to go right now. They are not Jackleg Joe or somebody down the road in a lab that we can't find. I need that to happen right now. So I don't—again—and can we—can I dialog to find out how to work that out or who to connect them to?

Dr. REDD. Yes.

Ms. JACKSON LEE. I thank you. Let me ask my good friend here in DHS—we have community spread in Texas, but I take issue with the non—the connecting flights.

So our community spread came through a person who came from Italy to Frankfurt to the United States. CBP is not prepared. You need to implement some form of testing for CBP in terms of asking the question of whether or not the person has come from Italy, period.

The other point is, there are 3 TSO officers diagnosed in San Jose. Can you just give me an answer of what you are doing to ramp up preparation from those airports?

Ms. UNDERWOOD. The gentlelady's time——

Ms. JACKSON LEE. If I can get that answer——

Ms. UNDERWOOD [continuing]. Has expired.

Ms. JACKSON LEE [continuing]. I would appreciate it on the record.

Ms. UNDERWOOD. Yes. So——

Ms. JACKSON LEE. Thank you. If—and Deputy Secretary, thank you.

Mr. CUCCINELLI. The 3 TSOs are all at one airport, San Jose International——

Ms. JACKSON LEE. Right. But——

Mr. CUCCINELLI [continuing]. So 46 other employees have been sent home for self-quarantine.

Ms. JACKSON LEE. I want to do TSO across the Nation. I don't want to—I am just saying that they are susceptible.

Ms. UNDERWOOD. The gentlelady's time has expired. She posed a number of questions. Perhaps you can submit the answer in writing, sir. The Chair now recognizes Mr. Higgins for 5 minutes.

Mr. HIGGINS. Thank you, Madam Chairwoman. Mr. Cuccinelli. Does your job description include advising and reporting the Executive and the Department of Homeland Security based upon your mission parameters and your background, your own personal experience and knowledge?

Mr. CUCCINELLI. Yes, sir.

Mr. HIGGINS. Dr. Redd, does your job description include advising the CDC and HHS regarding your background as a doctor and your specific mission requirements?

Dr. REDD. It does.

Mr. HIGGINS. Do you gentleman know Dr. Anthony Fauci?

Dr. REDD. Yes.

Mr. HIGGINS. Would you consider him to be a brilliant scientist with an incredible medical background and an expert on allergy and infectious diseases?

Dr. REDD. I would.

Mr. HIGGINS. Would you, Dr. Redd, concur with Dr. Fauci's conclusions that based upon his scientific assessment and his job description as an advisor and a counselor based up a scientific data, would you concur with his conclusion that large gatherings of Americans—it would be best to slow the spread of this virus if there were not large gatherings?

Dr. REDD. Yes.

Mr. HIGGINS. Did that concurrence with his opinion that is based upon science and medicine; is it now?

Dr. REDD. It is. There are elements to that, that we could go into, but, yes.

Mr. HIGGINS. So in—on a clean slate, that is strictly medical and scientific advice, correct? That is his job? Your job and Mr. Cuccinelli's job is to advise the Executive?

Dr. REDD. Yes, sir.

Mr. HIGGINS. You swore an oath when you took office, did you not, sir?

Dr. REDD. Did——

Mr. HIGGINS. Your oath was to the Constitution, was it not?

Dr. REDD. Yes, sir.

Mr. HIGGINS. It has been alarming to me to hear suggestions in this committee and others that there seem to be suggestions that there be some Federally-mandated overriding authority to enforce restrictions of travel of free Americans and to override the authority of sovereign States and the Governors thereof to mandate the enforcement of restrictive gatherings of free Americans.

We are not Italy. We are not South Korea. We are certainly not Beijing. We are not Hong Kong. This is America. I have a great deal of concern that this virus—and let's talk about that for a second.

There has been a lot of talk about preparedness in this committee and others. Does the CDC have stockpiles of millions of test

kits and vaccines for a virus that may surface next year that we don't know what it is?

Dr. REDD. No, we do not. And——

Mr. HIGGINS. Of course not.

Dr. REDD. In fact, the—that——

Mr. HIGGINS. When was COVID–19 first discovered within an American certified scientific lab and evaluated and said, yes, this is COVID–19. This is a new virus?

Dr. REDD. It was in January 2020.

Mr. HIGGINS. Thank you very much. Did we have stockpiles of prepared tests that—these tests must be virus-specific; am I correct?

Dr. REDD. They are. We started producing them before we had the virus. Actually, one the sequence was produced in early——

Mr. HIGGINS. But you had the scientific sequence?

Dr. REDD. We did.

Mr. HIGGINS. So there is no way for us now to know what that sequence is for a virus that may be discovered next year, is there?

Dr. REDD. Correct.

Mr. HIGGINS. So other than having infrastructure of our massive Federal Government working in cooperation with international organizations and our State and local governments and—including private industry, did—well, how more prepared could a nation be for a unknown virus then we are right now? Now, surely, we will learn from this. Do you agree?

Dr. REDD. I do. We will——

Mr. HIGGINS. We will be better and stronger as we move forward. Did we learn from SARS?

Dr. REDD. We did. We learned quite a bit over the last 20 years in emergency responses. If I could just go back to one of your earlier points.

Mr. HIGGINS. Please do.

Dr. REDD. If I may, we work closely with State and local governments. We don't make decisions for what they should do. We are really at their service providing that kind of technical and scientific guidance that you described. So we don't make those decisions.

Mr. HIGGINS. I concur as we should as a Federal Government and a Constitution that is represented to republic of sovereign States.

Dr. REDD. Yes, sir.

Mr. HIGGINS. So the Governors of our sovereign States have been instructed and advised and empowered to make decisions within their States; is that correct?

Dr. REDD. Absolutely.

Mr. HIGGINS. Would you see the role of the Federal Government in any other way?

Dr. REDD. I wouldn't—you know, I think there are places where things like quarantine authority—there are State authorities. There are Federal authorities. You know, those are things we have to work out. But in general at CDC we work in the service of the State governments.

Mr. HIGGINS. Well, thank you for service, gentleman. Both of you, thank you for appearing before this committee today. It has

just been fascinating. Madam Chairwoman, thank you for holding this hearing.

Ms. UNDERWOOD. The Chair now recognizes Mr. Thompson.

Chairman THOMPSON. Let me get something straight, Dr. Redd. We just approved $8.3 billion last week to go to State governments because they don't have the capacity to do exactly what we are dealing with. So now are you agreeing that States ought to do their own thing, and the Federal Government stay out?

Dr. REDD. We guide—we provide advice to States. So it is—we work at their service. We are providing a lot of funding through your appropriation to do the things that we all agree need to be done.

Chairman THOMPSON. But we giving them a heck of a lot of money. So I don't think you can become a sovereign State and not rely on your Federal Government to help in times of pandemic.

Dr. REDD. Well, it—I think that we are certainly doing everything we can to support the States, but they will be the ones making these kinds of decisions. I am not following you——

Chairman THOMPSON. Dr. Redd——

Dr. REDD [continuing]. I think. I am——

Chairman THOMPSON. I think there are some health decisions CDC makes independent of the States.

Dr. REDD. We really work—the way that CDC primarily operates is by collecting information, analyzing it, and then translating that into guidance or recommendations. We work very closely with State health departments and State governments, but at the end of the day for these kind of things we are talking about close this event—it is going to be a State decision.

Chairman THOMPSON. But States rely on CDC?

Dr. REDD. They do. We have——

Chairman THOMPSON. That is what I——

Dr. REDD. Yes, I think it is a partnership really.

Chairman THOMPSON. No State on its own can survive a situation that we are dealing with right now without the help of CDC.

Dr. REDD. Yes. That would be my opinion. I——

Chairman THOMPSON. That is what I am trying to get at.

Dr. REDD. Yes.

Chairman THOMPSON. Thank you. I yield back.

Ms. UNDERWOOD. OK. The Chair now recognizes Mr. Correa for 5 minutes.

Mr. CORREA. Thank you, Madam Chair. I want to thank the Chairman for holding this most important issue. I want to welcome both of our witnesses, Dr. Redd and Mr. Cuccinelli for being here today. I just want to say we are all in the same team so to speak.

Mr. Cuccinelli, you said earlier you—I don't want to put any words in your mouth that you didn't want to essentially get in the way of local efforts—didn't want to interfere, didn't want to step on any of those efforts; is that correct, something to that effect?

Mr. CUCCINELLI. Along the same lines that Dr. Redd was just——

Mr. CORREA. The reason I bring that up is I try to have a town hall last Friday. My town hall in my district because really to get information out—and I encountered very shy county health officials

who didn't want to get ahead of this issue. There is a lot of confusion out there right now. This issue is evolving on a daily basis.

Mr. CUCCINELLI. It is.

Mr. CORREA. World Health Organization just declared a world pandemic. Who is in charge?

Mr. CUCCINELLI. The way that the——

Mr. CORREA. Is it——

Mr. CUCCINELLI [continuing]. Leadership for this——

Mr. CORREA. Is anybody in charge? Is anybody quarterbacking this effort at the Federal level or is this left to 50 States? Again just asking because my constituents want to know what is going on. What really unnerves individuals is you have got information, misinformation coming at you from all sectors.

So you got a Congressman, not a doctor, holding a town hall trying to explain to people with a couple of other individuals there who are doctors what is going on when my local county health officials don't want to step into this issue. Who is in charge?

Mr. CUCCINELLI. So the answer to your question, Congressman, is both which doesn't help with the confusion side.

Mr. CORREA. Both what?

Mr. CUCCINELLI. Our authorities are limited and our capacity.

Mr. CORREA. But you do have a voice——

Mr. CUCCINELLI. Absolutely.

Mr. CORREA [continuing]. Of authority based on science we hope——

Mr. CUCCINELLI. Yes.

Mr. CORREA [continuing]. To let people in this country know what the state of this Nation is. It is not about State's rights. It is not about Federal rights. It is about health issues and science.

Mr. CUCCINELLI. So among the things we have been doing, Congressman—I don't even know how many calls I have been on with literally hundreds and thousands of local health officials, legal authorities, like——

Mr. CORREA. But are we——

Mr. CUCCINELLI [continuing]. Attorneys and so forth——

Mr. CORREA. We need to continue——

Mr. CUCCINELLI [continuing]. To talk them through this.

Mr. CORREA [continuing]. To step up and really make that voice clear and concise to folks as to what we need to do. Very quickly, I am going to shift over.

Dr. Redd, I don't want to start any rumors here, but it is my understanding that the World Health Organization created a diagnostic test early on and offered it to the United States.

That the administration essentially decided to forgo using this World Health Organization COVID–19 diagnostic test and instead to have CDC develop its own; is that correct?

Dr. REDD. The tests were being developed at the same time at CDC. It is actually in Germany where the test was actually being developed. The WHO has kind-of a recipe for what the test—kind-of the characteristics of the test.

Mr. CORREA. So they weren't ahead of us? It was just almost parallel in terms of our efforts?

Dr. REDD. Correct. It was——

Mr. CORREA. Were those efforts coordinated?

Dr. REDD. We knew about their tests, but in terms of joint development it was independently developed.

Mr. CORREA. If I would ask, why we are not coordinating? This is a world pandemic—easy to figure that it is coming our way—China, Italy, Iran. Why would we not coordinate?

Dr. REDD. At that time, it was just China when we were beginning development of the test. The issue—maybe this is a later question that you would have. But when the issues with our tests were identified, there was sort-of a decision to make about how to proceed in correcting that issue.

If we had gone to the other tests, we would have kind-of gone back to zero with the FDA in terms of the emergency use authorization. So I am not——

Mr. CORREA. Lessons learned, can we figure out how to coordinate on a world-wide basis when we are looking at these kinds of world pandemics coming at us: Zika—OK—Ebola, corona. Something is going to come around the corner. I think our constituents—our tax payers—deserve that we learn lessons and react to this stuff on a world-wide basis immediately.

Mr. CUCCINELLI. Congressman, can I comment?

Mr. CORREA. Yes, sir.

Mr. CUCCINELLI. So on January 6, CDC reached out to their compatriots—the Chinese CDC taking its name from ours and offered to cooperate and to help them.

Their scientists as I understand it were agreeable to that, were enthusiastic about it, but their political leadership wouldn't act on those communications for weeks and weeks and weeks.

You heard Secretary Azar I am sure publicly complain eventually of that—the Chinese were taking so long to let the WHO team into China. That team included America representatives.

Mr. CORREA. Thank you.

Ms. UNDERWOOD. Colleagues, Members are reminded that votes have now been called. We are going to try to finish up the line of questioning, OK. So we are going to ask Members to be thoughtful as they proceed. The Chair now recognizes Mr. Richmond for 5 minutes.

Mr. RICHMOND. Let me just follow up where my colleague left off. We are talking about lessons learned.

Mr. Cuccinelli, you mentioned that what China wouldn't do. But isn't that what our leadership is supposed to do? I mean people are not always going to just volunteer and follow, but that is what we have our American leadership for, right?

Mr. CUCCINELLI. Well, and our leadership reached out at both the Secretary and Presidential level. By Secretary, I mean two secretaries, Secretary Azar and Secretary Pompeo and the President all reached out to their counterparts in China during that time period.

Mr. RICHMOND. My suggestion would be sometimes you don't take no for an answer. That would just—especially when you are playing with something this important. But let me—I need to just explain to my colleagues, how many tests does South Korea do in a day?

Dr. REDD. They are doing a very large number of tests each day. They have got 60 sites that are drive-thru, many more tests than we are doing.

Mr. RICHMOND. So people in my district are not going to understand how South Korea are ahead of us because we are the United States of America. It is not the time to complain about it, but we need to have that figured out.

Because let us take a community like New Orleans that is high on tourism—the port is our biggest industry, tourism is our second—when it comes we are in a world of trouble, especially if we don't have the ability to test like we should. So when do you think we would have that ability in New Orleans to test as we would need.

Dr. REDD. So the ability to test is increasing day by day. We have sent—we have got 2 systems to do tests in the United States. We have the public health system. There are 75,000 tests out there in that system now. There are over a million tests in the commercial sector with that number increasing almost daily.

The place where we have work to do is making sure that when a patient—a doctor decides a patient needs a test, they can get it that day and can get results back quickly.

I think from the standpoint of being able to respond effectively and to kind-of know where we are, a lot of the things that we are doing now are going to clarify actually where we are. For example, community surveillance to make sure if there is a virus—not even having to go and say I think I have coronavirus.

But if you have respiratory symptoms, there are systems around the country that we are standing up to test people, not just for influence which is what those systems were designed for, but also for coronavirus. So we will be able to detect transmission in a way that doesn't require that prompting.

Mr. RICHMOND. So the technical support that you all are offering to local municipalities that would include tracing?

Dr. REDD. You know, it depends on where we are in the epidemic. The contact tracing is—again is a really important measure when you want to extinguish transmission. That was what we have been doing in the early parts of the epidemic.

When you have community transmission, there is just—it is just not feasible to do that. The effort is better directed toward the kind of recommendations that you are seeing in King County, in Santa Clara, in New York which is protect the elderly and do things at a community level that can prevent transmission.

Mr. RICHMOND. That would be—that would be my question because I guess what I am hearing in New Orleans now—we have put in a request for technical support from the CDC. It appears that we have a case of an elderly person who lived either in assisted living or a nursing home.

So we are going to need all the help we can get and we are going to need it real quick. Are you all prepared to assist in an event like that?

Dr. REDD. So I think that the—as there are more nursing—I think what we need to do is to protect nursing homes.

Mr. RICHMOND. Let's——

Dr. REDD. I can't promise you that we are going to send a team to New Orleans, but we are going to help the health department in every way that we can.

Mr. RICHMOND. OK. So the answer is you don't know. Let me also ask very quickly, do we think that—and this is about the future, about putting pandemics under the Stafford Act so that when it happens we can mobilize without having to come to Congress.

We can do individual assistance. We can do all the things we need if we put it under Stafford Act, include it with natural disasters. Is that something we should do?

Dr. REDD. I think that one of the things that we have learned from previous experience is very important work Congress has done is to create the Infectious Disease Rapid Response Reserve Fund.

That allowed us to respond immediately and not be delayed waiting for an appropriation. I think the question of whether the Stafford Act is the right mechanism or not or there is some other mechanism is one that I think we need to have a dialog about. But it is—it is essential that large emergency responses like this not be hindered by the lack of funding.

Mr. RICHMOND. I yield back.

Ms. UNDERWOOD. Thank you. The Chair now recognizes Mr. Green from Texas for 5 minutes. OK. If the gentleman yields to Ms. Titus for 5 minutes.

Ms. TITUS. Well, thank you, Mr. Green. I appreciate that very much. I will just be brief. Mr. Cuccinelli, I think you said earlier that you rejected the academic models that advised against travel boundaries or travel restrictions and gave the advice to the President to the contrary.

What would make you think you could reject an academic model based on scientific study and evidence to advise the President? Was that like bad politics as opposed to good science?

Mr. CUCCINELLI. Well, I am not quite sure how to answer your last question.

Ms. TITUS. Well, I think I know the answer.

Mr. CUCCINELLI. It was our——

Ms. TITUS. I think it probably was. And this——

Mr. CUCCINELLI. It was our best judgment——

Ms. TITUS [continuing]. Administration has very little——

Mr. CUCCINELLI [continuing]. As a task force.

Ms. TITUS [continuing]. Respect for——

Mr. CUCCINELLI. And——

Ms. TITUS [continuing]. Anything intellectual. And this is yet another——

Mr. CUCCINELLI. Do you actually want me to answer the question?

Ms. UNDERWOOD. Gentleman will suspend.

Ms. TITUS. No, that is fine.

Ms. UNDERWOOD. Gentleman will suspend.

Ms. TITUS. If you can answer this question for me though, Mr. Cuccinelli. As the acting director, you oversaw the roll out of the very cruel public charge rule. Now, we heard yesterday from the director of the CDC that the public charge rule would discourage

people from seeking the health care they need amidst this outbreak.

Could you comment on this, Dr. Redd? Do you think the fact that people don't have coverage or they are afraid to get Medicaid because they are afraid they will lose their green card, this could have some impact on the spread of this virus?

Dr. REDD. I am not familiar with that rule. I think we should be doing everything we can to make sure that people that need to get tested and need treatment have access to it.

Ms. TITUS. Thank you, Dr. Redd. In light of that, Mr. Cuccinelli, would you recommend that we take away that global—I mean that public charge rule?

Mr. CUCCINELLI. Do you want me to actually answer?

Ms. TITUS. I would like an answer.

Mr. CUCCINELLI. Oh, all right. Well——

Ms. TITUS. It is a yes or no.

Mr. CUCCINELLI. No.

Ms. TITUS. Why not?

Mr. CUCCINELLI. Oh, I thought it was just yes or no.

Ms. TITUS. That is next question.

Mr. CUCCINELLI. So the—because it is completely unrelated. Anyone seeking help or testing or health care related to the coronavirus does not affect a public charge analysis.

Ms. TITUS. I guess the director of the CDC would disagree with you. That is what he testified before House Appropriations yesterday.

Mr. CUCCINELLI. If he so testified, he was wrong.

Ms. TITUS. OK. Thank you. I yield back.

Ms. UNDERWOOD. The Chair now recognizes Mr. Green from Texas for 5 minutes.

Mr. GREEN of Texas. Thank you, Madam Chair. Dr. Redd, if I may—and I will try to move expeditiously because my dear friend Mr. Cleaver is here, and I would like for him to have his turn. You have indicated that in South Korea they test people in their cars as they drive-thru, true?

Dr. REDD. Yes, sir.

Mr. GREEN of Texas. You have indicated that they test some 60,000 people?

Dr. REDD. I didn't give a number, but that sounds right.

Mr. GREEN of Texas. Per day.

Dr. REDD. I am not sure if that—I can't verify that number. We can check. I have got it in here, but I don't recall the exact number.

Mr. GREEN of Texas. How many do we test per day in this country?

Dr. REDD. It is not that high.

Mr. GREEN of Texas. Is it 40,000?

Dr. REDD. So we have—at CDC we have tested——

Mr. GREEN of Texas. Is it 30,000?

Dr. REDD [continuing]. One thousand seven hundred people—1,784. State health departments——

Mr. GREEN of Texas. Is it——

Dr. REDD [continuing]. Have tested——

Mr. GREEN of Texas [continuing]. Twenty thousand?

Dr. REDD. I am sorry.

Mr. GREEN of Texas. Is it 20,000 per day?
Dr. REDD. It is not 20,000 a day.
Mr. GREEN of Texas. Is it 10,000——
Dr. REDD. It is on the border of——
Mr. GREEN of Texas [continuing]. Per day?
Dr. REDD. I really want to get back to you——
Mr. GREEN of Texas. Is it 5,000 per day?
Dr. REDD [continuing]. With numbers? I would like to get back to you with the numbers.
Mr. GREEN of Texas. Is it a number that exceeds 10,000 per day?
Dr. REDD. It is not a number that exceeds 10,000 a day.
Mr. GREEN of Texas. Is it a number that exceeds 5,000 per day?
Dr. REDD. I would like to——
Mr. GREEN of Texas. Is it a number that exceeds 3,000 per day?
Dr. REDD. I think it would be better for me to get back to you——
Mr. GREEN of Texas. Does it exceed——
Dr. REDD [continuing]. With an exact number.
Mr. GREEN of Texas. Does it exceed 1,000 per day?
Dr. REDD. As I said before, it would be better if I got back to you with the correct number.
Mr. GREEN of Texas. Is it true that there is a way to test thousands of people per day?
Dr. REDD. I think that we are going to be seeing that——
Mr. GREEN of Texas. Is it true——
Dr. REDD [continuing]. In the commercial sector.
Mr. GREEN of Texas [continuing]. That the technology exists such that thousands of people per day can be tested?
Dr. REDD. Yes.
Mr. GREEN of Texas. Is it true that if this technology exists that the United States of America, greatest, richest country in the world, can employ this technology?
Dr. REDD. I think that we will be doing that in the commercial sector.
Mr. GREEN of Texas. Yes, is it true that the United States of America regardless of setting can deploy this technology?
Dr. REDD. It certainly is possible.
Mr. GREEN of Texas. In the United States of America is it not true that we can put a person on the moon?
Dr. REDD. We have.
Mr. GREEN of Texas. Yes, we have. So is it fair to say that if they are doing it in South Korea that we can—maybe we can ask them how to do it.
Dr. REDD. We are in discussions with them about their response. One maybe 2 points to make, I think that at the end of the day——
Mr. GREEN of Texas. Is it also true——
Dr. REDD [continuing]. Our——
Mr. GREEN of Texas [continuing]. That if we had 1 million people tested that we would not be able to ascertain the results within any reasonable amount of time because we don't have the methodology, the means by which we can examine the test and do it in an efficacious way such that we can give results with some degree of immediacy? Is this true?

Dr. REDD. Well, it is one of the things that we are working on——

Mr. GREEN of Texas. Is it true that——

Dr. REDD [continuing]. To do.

Mr. GREEN of Texas [continuing]. If we had a million people tested, we would not be able to get the results back immediately?

Dr. REDD. I think that the answer to your question——

Mr. GREEN of Texas. Is it true that it would take longer than a week to do that, to get the results back?

Dr. REDD. I am sorry. I am trying to answer your question.

Mr. GREEN of Texas. I understand it. I am trying to ask a question. Is it true that it would take longer than 2 weeks to get the results back?

Dr. REDD. I think that there is——

Mr. GREEN of Texas. It is true that it would take longer than 3 weeks?

Dr. REDD. I think the systems exist now to get results back to patients more quickly, particularly——

Mr. GREEN of Texas. If we had a million people tested—we are talking about a million—how long?

Dr. REDD. Well, people get blood tested every day, and there are more than a million people. They get their results back the same day.

Mr. GREEN of Texas. But I am asking you about current circumstances—current circumstances. As we sit here waiting for this answer so that we can vote, how long?

Dr. REDD. I think what we could get back to you with is for the—the companies that are——

Mr. GREEN of Texas. The truth is there is——

Dr. REDD [continuing]. On a routine basis.

Mr. GREEN of Texas. There is a way to do this testing. It appears to me that we don't have the will. We don't have the will to move expeditiously to acquire the technology if we don't have it. We can do this.

This country has the ability to get great things done in short order. We for whatever reason don't have the will. Public becomes highly suspect when we don't exercise the will where you have few facts. You have much speculation. The speculation is going to run rampant because we don't exhibit the will to do that which can be done.

Dr. REDD. I respectfully disagree with you, sir.

Mr. GREEN of Texas. I will expect you to respectfully disagree, but I respectfully disagree with your disagreement. I yield back the balance of my time.

Ms. UNDERWOOD. The Chair now recognizes Mr. Cleaver for 5 minutes.

Mr. CLEAVER. Thank you, Madam Chair. I won't use 5 minutes. Admiral, thank you. I am—this is I guess a little personal, but it probably has some applicability to the entire country. My father is 97. He won't take the flu shot because he thinks it will make him get the flu.

By the way, my grandmother said that messing around with the moon messed up the weather and the flowers. So if we went up there, we made some mistakes while we were on the moon.

But let me get back to my dad because he is healthy as far as we know—97 years old. But he is already suspicious of things. Then we are told that your shop wanted to advise elderly Americans, you know, not to do certain things because 97 years old or whatever your immune system is vulnerable. That it was overruled.

I am concerned about people out here who are—who may be sick. They already—older people—already suspicious. Then they can't get accurate information about their immune system and the vulnerability to this galloping virus.

You know, we are probably going home tomorrow. We got to deal with—I do—I am—in my real life I am a Methodist pastor. I am going to deal with people this weekend wanting to know what is going on.

You know, the White House says, you know, it is OK. You don't need to worry about CDC said if you are older—an older person, don't get on planes and so forth. What—Mr. Cuccinelli—somebody—would you like to come to speak to the church or call my father?

Dr. REDD. I think the question of distrust of authorities and for example with the influenza vaccination is a really difficult problem. I think it really gets back to the question of trust that we have talked about——

Mr. CLEAVER. Yes.

Dr. REDD [continuing]. To some extent today. And——

Mr. CLEAVER. I am not blaming you. I am just—I just want to know how did we get into this mess because it is—I think it is going to—because it——

Dr. REDD. Well——

Mr. CLEAVER. We could cause some people to——

Dr. REDD. I think your son is going to believe you more than he is going to believe us. So I would recommend that you give him the advice that is on the CDC website, and do your best to encourage him to stay protected.

Mr. CLEAVER. But what about flying? What about elderly people flying?

Dr. REDD. I think that, that is for a 90-year-old person today, I would not recommend flying.

Mr. CLEAVER. Why would it be overruled? I mean I don't—maybe I am not articulate enough, but——

Dr. REDD. Well, I actually—in the guidance that we have that is—we do recommend that for——

Mr. CLEAVER. Yes, but—I had to cut you off. But earlier we were—the White House said don't make that information available. That is all I want to know is why?

Mr. CUCCINELLI. No, sir. There has not been a point where we have said or anyone at the White House has said don't make X information available.

Mr. CLEAVER. OK. Well, these news reports are I guess——

Dr. REDD. I think maybe there is an interpretation of close space with limited air circulation. That—you know, there are ways to interpret that.

Mr. CLEAVER. OK. I don't have time. The news reports that is—I don't have the time to do this in here right now. But I had news

reports. I can get them—get it to you—which said that CDC said they wanted to issue this warnings to the elderly, and they were told not to do it by the White House, you know.

Dr. REDD. Well, I think—you asked me for an interpretation of our guidance. That was——

Mr. CLEAVER. Yes.

Dr. REDD [continuing]. The interpretation I gave.

Mr. CLEAVER. I appreciate that. I appreciate that.

Mr. CUCCINELLI. Yes, and Congressman, I have participated in the task force, and CDC has been a critical central member of it from the beginning of course. As Dr. Fauci testified in one of—he didn't testify.

It was a press conference. As he said when he was directly asked, you know, have you been muzzled, he said, "I have been doing this for 30-plus years." I don't remember his whole exact answer. He said——

Mr. CLEAVER. I hear you.

Mr. CUCCINELLI [continuing]. Nobody has told me to not say anything.

Mr. CLEAVER. I heard it.

Mr. CUCCINELLI. That has been the case with the whole—with the CDC as well.

Mr. CLEAVER. Thank you.

Ms. UNDERWOOD. OK. The gentleman's time has expired. I ask unanimous consent to enter into the record a statement from the American Federation of Government Employees.

Without objection.

[The information referred to follows:]

STATEMENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

MARCH 11, 2020

Chairman Thompson, Ranking Member Rogers and Members of the committee: On behalf of the American Federation of Government Employees, AFL–CIO (AFGE), which represents more than 700,000 Federal and District of Columbia employees who serve the American people in 70 different agencies, including approximately 100,000 employees at the Department of Homeland Security (DHS), thank you for holding this hearing entitled "Federal Coronavirus Response." AFGE has serious concerns involving the administration's efforts to prevent, detect, and treat Coronavirus, or COVID–19, as it relates to the Federal workforce and the American public. In addition to employees at DHS, our union represents thousands of workers who are health care professionals at the Department of Veterans Affairs (VA), the Department of Defense (DoD) and the Bureau of Prisons (BoP) and the many Federal workers whose jobs require regular contact with the public. Their health and safety as they continue to provide services to the public is essential to our homeland security.

Health care providers and emergency responders such as workers at the Federal Emergency Management Agency (FEMA) are among those Federal employees who have been or are likely to be called upon to provide services to populations infected with COVID–19 or populations at risk of infection. Workers who provide patient care and emergency responders should be accorded the highest priority for disease prevention measures. Additionally, Transportation Security Officers (TSOs), employees at the U.S. Citizenship and Immigration Services (USCIS) and Customs Enforcement (ICE) are in positions that require interaction with the public and should be considered as at-risk for contracting the virus.

AFGE is concerned that safety protocols have not been sufficiently communicated to the front-line workforce, and adequate personal protective equipment such as gloves, effective masks, and hand cleaner have not been deployed to an adequate extent. Agencies are not communicating with their workforces to a degree that will allow them to protect themselves or the public adequately in order to contain the

spread of this virus. In most cases, employees have only been given a link to the Centers for Disease Control website, told to monitor the news and stay home if they do not feel well. The Office of Personnel Management (OPM) has likewise provided only vague instructions in three successive efforts to communicate the administration's plans for the Federal workforce.

For many DHS employees, remote workstations or telework are not options. However, we urge the committee to insist that the Acting Secretary move immediately to allow all employees who are capable of performing their duties via telework to begin doing so immediately. For those who are not currently telework-ready, but whose jobs can be performed in that capacity, this must include provision of necessary equipment and remote work training to maximize employees' ability to continue to perform their duties. Many of these employees provide crucial support functions to the front-line workforce and are essential to ensuring the continuity of homeland security and emergency operations. The White House Coronavirus Task Force (Task Force) directed OPM to include telework in its guidance to agencies, requiring them to incorporate telework in their continuity of operations plans. We urge the committee to insist that the Task Force provide regular communications to agency leadership and the workforce regarding its progress toward achieving this directive.

For those on the front lines such as first responders, law enforcement officers, TSOs, and all those with substantial work-related contact with the general public where telework is not practicable, we urge the committee to insist that the acting director adopt a policy, like the long-established precedent at the VA with Agent Orange, that if they are exposed, there is a presumption that the virus was contracted at work. As such, a front-line worker will have access through the Federal Employees Compensation Act (FECA) to full coverage of related medical treatment and for wage loss or disability related to that condition or associated complications from the illness.

Further, all Federal employees who are in positions where they may be exposed to COVID–19 should have rapid access to screening at no cost. DHS should also direct TSA to immediately retract its recent reductions of Federal Employee Health Benefit Program (FEHBP) coverage for its large part-time workforce and provide for a temporary open season to return to better health plans. These workers' share of premiums doubled, and with their low pay, many changed to less expensive policies with higher deductibles and less generous coverage. We cannot afford to have such artificial barriers to employees seeking the best possible medical treatment.

Workers who provide direct patient care and emergency services to individuals who have contracted COVID–19 do not have clear, specific guidance and effective preventive equipment and gear to protect themselves from contracting the virus. In other cases where workers are exposed to unusual hazards, current law provides for a pay differential, or hazardous duty pay. Because these workers are in immediate danger of exposure, and current protocols have no guarantees of protection, employees required to work and interface with individuals who have been quarantined or diagnosed with COVID–19 should qualify for hazardous duty pay.

AFGE recognizes that COVID–19 is spreading rapidly and that requirements of agencies and especially of the front-line workforce may change. As it does, we thank the committee for its on-going and diligent oversight as you work to protect the Federal workforce and the American public.

Thank you for your consideration.

Ms. UNDERWOOD. I thank the witnesses for their valuable testimony and the Members for their questions. The Members of this committee 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 committee stands adjourned.

[Whereupon, at 4:44 p.m., the committee was adjourned.]

APPENDIX

QUESTIONS FROM HONORABLE MICHAEL T. MCCAUL FOR KEN CUCCINELLI, II

Question 1. For those who have traveled from areas of high exposure to COVID–19, is traveler information being shared across the Government between DHS, State, and the CDC? If so, how does this process work and protecting those in the United States?

Answer. The multi-agency response entails information sharing between pertinent Federal agencies. Through interoperability agreements, traveler information is synthesized at U.S. Customs and Border Protection's (CBP) National Targeting Center (NTC) and shared with interagency liaisons from the Department of State (DOS) and the Centers for Disease Control and Prevention (CDC). When travelers arrive at the ports of entry, CBP and CDC personnel work together to identify travelers who have COVID–19 or are potentially contagious. This determination is made based on advanced information from the NTC and by CBP officer observation.

Travel history for every traveler is assessed against CDC guidelines, and travelers are referred for enhanced public health screening as needed. Symptomatic travelers, both those displaying symptoms of COVID–19 or symptoms of another potentially contagious disease, are referred for public health assessment according to CBP and CDC shared guidance, training, and policies.

On January 31, 2020, President Trump initially determined that the potential for wide-spread transmission of the coronavirus by infected individuals seeking to enter the United States threatens the security of the homeland. Accordingly, the President issued Proclamations 9984, 9992, 9993, and 9996, which suspend entry to nearly all foreign nationals who have been in China, Iran, or certain European countries at any point during the 14 days before their scheduled travel to the United States. American citizens, lawful permanent residents, their immediate families, and other individuals not subject to the Proclamations who arrive from impacted areas must travel through one of 13 airports where DHS has established enhanced entry screening capabilities. All individuals not subject to the Proclamations who are returning from an impacted area must self-quarantine for 14 days after arrival.

Upon arrival in the United States, travelers proceed to standard customs processing. They then continue to an enhanced entry screening where the passenger is asked about his or her medical history and current condition, and asked to provide for contact information for local health authorities. Additionally, some passengers will have their temperature taken. After the enhanced entry screening is complete, passengers are given written guidance about COVID–19 and allowed to proceed to their final destination. Once home, individuals must immediately self-quarantine in their home and monitor their health in accordance with CDC best practices. In order to ensure compliance, local and State public health officials will contact individuals in the days and weeks following their arrival.

Question 2. Does DHS need additional funds to combat the coronavirus pandemic?

Answer. The Department greatly appreciates Congress' support for COVID–19 funding provided in the CARES Act.

Among the needs we are encountering that is particularly acute are for those agencies reliant to one degree or another on fees. As you are aware, due to reduced travel, there is an impact to numerous fee accounts; however, not all will have an operational impact. For the accounts that will have an operational impact, the Department is working to identify mitigation strategies, although each fee account is different and potentially will have different mitigation options.

As the impact is better known and mitigation options have been identified and vetted, we will provide the details to you and your staff. The Department will continue to refine requirements as we execute to current funding levels and monitor emerging needs.

QUESTIONS FROM HONORABLE MICHAEL T. MCCAUL FOR STEPHEN C. REDD

Question 1. For those who have traveled from areas of high exposure to COVID–19, is traveler information being shared across the Government between DHS, State, and the CDC? If so, how does this process work and protecting those in the United States?

Answer. The Centers for Disease Control and Prevention (CDC) and Department of Homeland Security's (DHS) Countering Weapons of Mass Destruction Office have worked closely in screening travelers for COVID–19 illness and exposure at the 15 funneling U.S. airports; collection and rapid sharing of data have been significant elements of that partnership.

Prior to the COVID–19 pandemic, CDC has had a long-standing partnership with DHS, via the National Targeting Center, related to data sharing to facilitate contact investigations of travelers who may have been exposed to an infectious disease during flights and to implement Federal public health travel restrictions (i.e., "Do Not Board" list and Public Health Border Lookout record). More information about those restrictions is available here: *https://www.cdc.gov/quarantine/travel-restrictions.html.*

Since early February, CDC has participated in a National Security Council (NSC)-led collaboration with several agencies to look at Government-held data to determine where additional integration and data sharing could assist in public health follow-up programs on a larger and more rapid scale than occurs routinely. CDC has agreements with the Departments of State and Homeland Security that are either completed or in progress to improve sharing of available data for contact investigations and public health follow-up.

CDC is appreciative of the leadership of the NSC in this effort and continues to collaborate with our partners to look at Government holdings of traveler contact information and determining best practices for sharing this data to help address unmet public health contact tracing and traveler monitoring needs.

Question 2. Does DHS need additional funds to combat the coronavirus pandemic?

Answer. CDC defers to DHS for this response.