

January 31, 2022

The Honorable Richard Hudson
U.S. House of Representatives
2112 Rayburn House Office Building
Washington, DC 20515

The Honorable Jim Banks
U.S. House of Representatives
1713 Longworth House Office Building
Washington, DC 20515

The Honorable Tom Cole
U.S. House of Representatives
2207 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Hudson, Banks, and Cole:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the following comments to questions posed by the Healthy Future Task Force Security Subcommittee. It is critical that we use the lessons learned during the unprecedented COVID-19 pandemic to improve pandemic preparedness, public health, and supply chain issues.

PANDEMIC PREPAREDNESS

Enhance State and Federal Stockpiles and Improve the System for Acquisition and Distribution of Medically Necessary Supplies (Questions 1 and 2)

Acquisition of appropriate personal protective equipment (PPE) for health care providers has been a significant and ongoing challenge for physicians in every health care setting during the COVID-19 pandemic.¹ Hospital and health system physicians on the front lines struggled with limited supplies of basic PPE, compromising their ability to adequately protect physicians, other health care providers, and patients. As we shifted towards reopening non-hospital physician practices for elective visits and procedures, we faced new demands on the PPE supply chain. While we appreciate the overwhelming global demand for these critical products and the strain on the supply chain this created, below we offer some recommendations to help ease the burden on the Strategic National Stockpile (SNS), the distribution system, and help physicians, hospitals, and health systems address the problems that currently exist and better prepare for dealing with shortages of these critical supplies.

Throughout the early months of the COVID-19 pandemic in the United States, PPE, infection control products, and ventilators were in shockingly short supply, particularly in hot spots dealing with an exceptional case load. Procurement of PPE and other infection control products appeared to be a free-for-all, with the federal government claiming states were on their own to procure what they could, but the federal government also attempting to purchase large quantities of PPE and other items to distribute. The AMA was made aware that there was significant confusion as to where to acquire PPE, who was managing procurement (federal officials, state officials, individual facilities), how much PPE was

¹ See Mehrota et al., “Personal Protective Equipment Shortages During COVID-19 – Supply Chain-Related Causes and Mitigation Strategies,” available at <https://jamanetwork.com/channels/health-forum/fullarticle/2766118>.

available, and when more would be made available. Claims of federal requisition of items purchased by states were widely known and made it virtually impossible for states or individual hospitals to acquire needed supplies. This confusion put hospitals, physician offices, nursing homes, and health care workers on the front lines in an impossible situation where they did not have critical information necessary to plan for usage of PPE and other medically necessary supplies. **The AMA recommends the creation of a clear and transparent plan for acquisition and distribution of PPE and other needed supplies, with clear delineation of federal and state roles and requiring supply chain information be made available to physicians, hospitals, nursing homes, and health systems during public health emergencies.**

Increase funding and modernize planning for the SNS, create contingency plans and provide federal guidance on what supplies should be stockpiled and should be provided to states and local entities (Questions 1 and 2)

Funding for the SNS has decreased precipitously since 2003.² Moreover, funding and stockpile planning were inadequate to meet the demands of a nationwide extended epidemic.³ At the start of the epidemic, there were reportedly just 12 million N95 masks and 30 million surgical masks available in the national stockpile, an amount that would have been inadequate for any major viral outbreak.⁴ The SNS' priorities should be reassessed with future pandemics in mind. In particular, the strategic national stockpile should contain enough supplies to help bridge the gap while production is ramped up on PPE, diagnostic testing equipment, ventilators, and other necessary supplies when the next pandemic hits. **Given that we have learned that global demand can quickly outpace supply of even simple items such as cotton testing swabs, the AMA recommends that new plans and adequate, long-term funding be put in place for federal, and possibly state, stockpiles of critical testing supplies.** In addition, in order to better prepare for unforeseen challenges and demands on supplies, **the AMA recommends that the federal government be required to develop a contingency plan to best deal with supply shortages and supply chain issues impacting critical medical supplies during a pandemic, including ventilators, PPE, and testing supplies.** This may include best recommended alternatives to supplies in shortage, plans to engage alternative manufacturers that may be able to produce said supplies, or plans on when and how best to invoke the Defense Production Act. Also, in light of critical shortages of lab supplies throughout the current pandemic, including test kits, reagents, and now test tubes for drawing blood, Congress should consider adding lab supplies to the SNS.

Throughout the beginning of the current COVID-19 pandemic, access to PPE presented tremendous challenges to providers in all care settings. Many health care facilities were unsure where to turn to find information about available suppliers of PPE and infection control products. This was even more

² Greenberg, Jon. "Federal pandemic money fell for years. Trump's budget didn't help." Politifact, March 30, 2020. Available at <https://www.politifact.com/article/2020/mar/30/federal-pandemic-money-fell-years-trumps-budgets-d/>; Torbati, Yeganeh and Arnsdorg, Isaac. "How Tea Party Budget Battles Left the National Emergency Medical Stockpile Unprepared for Coronavirus." ProPublica April 3, 2020. Available at <https://www.propublica.org/article/us-emergency-medical-stockpile-funding-unprepared-coronavirus>.

³ Palmer, Doug "U.S. Medical Stockpile Wasn't Built For This, former director says." Politico, April 8, 2020. Available at <https://www.politico.com/news/2020/04/08/national-stockpile-coronavirus-crisis-175619>.

⁴ Levey, Noam M. et al. "A disaster foretold: Shortages of ventilators and other medical supplies have long been warned about." LA Times, March 20, 2020. Available at <https://www.latimes.com/politics/story/2020-03-20/disaster-foretold-shortages-ventilators-medical-supplies-warned-about>.

problematic for non-hospital practices, as they began to resume elective services and procedures. The AMA recommends that federal, state, and local entities managing pandemic response maintain readily available points of contact for questions about PPE and infection control supplies and logistics. Information about points of contact who can assist with questions must be made publicly available. Alternatively, the AMA recommends consideration of partnerships with clearinghouses that could provide assistance with sourcing and vetting of available PPE and matching supply with demand.

Moreover, given the crushing demand for PPE throughout the COVID-19 pandemic, federal, state, and local entities should all consider the merits of creating stockpiles of PPE, ventilators, and infection control products. **The AMA recommends the federal government work closely with state and local public health officials to assess local needs and provide guidance to states and local entities as to what those stockpiles should look like, and what should be included, as well as provide funding.** The federal government should provide transparency around what is included in the SNS, and when the SNS will and will not be utilized.

The Centers for Disease Control and Prevention (CDC) should provide clear guidance to health care providers, hospitals, and health systems on how to manage limited PPE, including guidance on how best to conserve PPE, guidelines for re-use, guidelines for sterilization/disinfecting, and alternatives when preferred PPE is not available. While the CDC did eventually provide this information during the current COVID-19 pandemic, the CDC should have permanent guidelines in place to address these critical issues and update these guidelines expeditiously as circumstances require. While COVID-19 was surging in hot spots such as New York City, providers in those locations did not have adequate guidance to instruct their use of PPE. Clear and timely communication from the CDC, the U.S. Department of Health and Human Services (HHS), and the White House is also key.

In sum, in order to prepare for future pandemics, the AMA:

- Urges the HHS Emergency Care Coordination Center, in collaboration with the leadership of the CDC, state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency;
- Urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the SNS and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti-microbial drugs, medical supplies, and PPE, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test, and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency;
- Encourages states to maintain medical and PPE stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

- Urges the federal government to meet treaty and trust obligations by adequately sourcing medical and PPE directly to tribal communities and the Indian Health Service (IHS) for effective preparedness and to respond to a pandemic or other major public emergency;
- Urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings; and
- Supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers.

Operation Warp Speed and Vaccine Development (Question 3)

The AMA agrees with the Subcommittee regarding the success of Operation Warp Speed in bringing COVID-19 vaccines to market. With unprecedented resources directed towards the rapid development, production, and deployment of the vaccines, Americans had access to highly safe and efficacious vaccines against COVID-19 in record time. We believe the operational plan and structure of Operation Warp Speed should be preserved in some form for future pandemics or when vaccines are otherwise needed on an urgent/emergent basis.

While the AMA does not think that critical changes to the regulatory oversight structure for vaccine authorization or approval are necessary at this time, we would like to highlight the critical need for transparency and education around the vaccine development and authorization/approval process. As anti-vaccine sentiment continues to grow around even the most established vaccines and vaccine misinformation is now rapidly disseminated upon authorization of a new product, transparency around the authorization and approval/licensing processes is critical so that both health care providers and patients have a clear understanding and rationale for the decision-making involved from credible, evidence-based sources. This transparency includes making public clinical trial data with an appropriate time for public inspection prior to any advisory committee meetings or authorization/approval/licensing action by the Food and Drug Administration (FDA) and continuing commitments to allowing for public comment in appropriate forums.

Additionally, the AMA has found that targeted educational efforts for physicians and other health care providers are critical during times of accelerated approval for novel products. In order for physicians and other health care professionals to be ambassadors of new vaccines and serve as educators for their patients and the general public, it is critical that they understand the process by which the vaccine came to market, the clinical data underlying the authorization/approval/licensure, and the technology itself. We strongly encourage the FDA to have in place plans to collaborate with key health care stakeholders to provide this critical education in advance of availability of any vaccine.

Flexible and Sustainable Funding Necessary to Bolster Public Health Preparedness (Question 4)

The Subcommittee notes that supplemental appropriations for the United States' early pandemic response and proposed transfers of funds illustrated the need for HHS to act quickly and draw upon all available funding, despite the existence of the Infectious Disease Rapid Response Reserve Fund and the Public Health Emergency Fund. We agree and think that in order for HHS to act quickly in future pandemics, Congress should provide long-term, sustainable funding for these two funds. While we understand that it is challenging to plan for and set aside funding for future unknown pandemics or infectious disease outbreaks, the COVID-19 pandemic has illustrated the dangers of failing to have long-range planning and adequate funding to respond to such events. HHS should have flexibility with dedicated funding to direct those funds where they are needed most to improve timely response to infectious disease outbreaks.

Regulatory Barriers (Question 5)

The AMA believes that, throughout the course of the pandemic, federal departments and agencies, as well as Congress, appropriately exercised flexibilities that allowed them to generally respond to pandemic needs. While it appears that there is ample opportunity for regulatory flexibility within currently regulatory confines, there are some areas that Congress may examine whether updates are needed. First, it may be appropriate to examine the Emergency Use Authorization (EUA) process at FDA as it pertains to pandemic testing. Early in the pandemic, the AMA heard from numerous pathology members and laboratory stakeholders that, despite the EUA process' supposed flexibility, somewhat stringent requirements for validation data in advance of putting a laboratory developed SARS-CoV-2 test in use were too limiting and delayed the ability of capable, accredited labs such as those in academic centers and other hospitals/health systems to quickly utilize SARS-CoV-2 laboratory developed tests (LDTs) in their facilities. It also appears that FDA regulatory requirements may have limited the availability of rapid antigen tests, especially those manufactured outside the U.S. We urge Congress to consider whether FDA needs additional authorities to allow for additional flexibilities or to consider options to utilize international partners/consortiums that can assist in evaluating and approving for use antigen tests developed and manufactured globally. We also urge Congress to consider mechanisms to ensure at-home antigen tests are appropriately priced. The AMA is aware that the prices of these tests in the U.S. are significantly higher than those paid by individuals in other countries, such as those in the United Kingdom (where a significant number of tests are provided to each citizen at no cost) and in the European Union, where they are frequently available under \$5 per test as opposed to the \$10-\$12 per test in the U.S.

Additionally, the AMA applauds the flexibilities provided for physicians to be reimbursed for telemedicine and audio-only services for patients. Throughout the pandemic, telemedicine services became critical to management of acute and chronic illnesses at a time when in-person visits posed significant risk of COVID-19 transmission. **The AMA strongly supports the "Telehealth Modernization Act of 2020" and applauds the inclusion of this bill in Cures 2.0.** It is critically important that Medicare beneficiaries continue to be able to access telehealth services from their physicians without arbitrary restrictions throughout the COVID-19 public health emergency and beyond. This bill would provide this coverage by eliminating section 1834(m) statutory restrictions on originating site and geographic location, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located. **We strongly encourage Congress to make permanent the telemedicine waivers to allow continued reimbursement for these critical services without the existing geographic and originating site restrictions.**

Additional Areas for Consideration

In developing strategies to combat future pandemics, we urge Congress to consider how the COVID-19 pandemic has had a profound and disproportionate effect on minoritized and marginalized communities. While the data remains incomplete, the data that have emerged on the racial and ethnic patterns of the COVID-19 pandemic show that the virus has clearly disproportionately affected Black and Latinx, American Indian/Alaska Native—particularly in the Navajo Nation—Asian-American, and Pacific Islander communities in terms of infections and deaths. Policy solutions aimed at preparing for the next pandemic must have an acute focus on protecting underserved areas and marginalized communities. This must include a comprehensive and well-coordinated data collection strategy, that takes into account sensitivities when collecting demographic information from historically marginalized populations. In addition to better collection of information about which communities face the highest burden of disease, any future plan for addressing a pandemic must prioritize promptly providing culturally appropriate public health information to minoritized populations through appropriate channels and ensuring access to testing and telehealth services for underserved areas in order to identify pandemic spread and assist those communities in gaining access to health care services while maintaining physical distancing.

One of the significant challenges of the current pandemic during its first year was the lack of clearly delineated roles and responsibilities with respect to the public health emergency response within federal departments and agencies. There was also a lack of coordination between individual states and the federal government, as well as a lack of understanding what role each was to play in the response. While much of this has improved, there is still a need to provide clarity and ensure coordination so that public officials may more quickly and efficiently respond to an impending public health crisis. As Congress considers how best to deal with future public health emergencies, we recommend that a national strategy for response coordination be put in place that clearly outlines the roles and responsibilities of both federal and state governments. **The AMA strongly recommends a mandate that requires creation of a national strategy for response coordination, clearly delineating the roles of federal and state governments in public health emergencies, so that each can properly prepare and move quickly the next time we face a national public health crisis like COVID-19.**

In addition, the needs of physicians and patients in all practice settings must be considered to ensure continuity of care for patients and continued viability of non-hospital practices. When responding to an emerging global health threat, we must urgently respond to and prioritize the needs of front-line providers helping to mitigate the impacts of public health emergencies. While these needs understandably take precedence in the midst of a crisis, we also must continue to consider the impacts of public health emergencies on non-hospital providers and patients needing management of chronic conditions. Non-emergent medical services were rightly halted at the beginning of the COVID-19 pandemic, but we need to be better prepared in a future epidemic to address the needs of non-hospital providers and patients with chronic conditions who have to make in-person visits to a physician's office or other health care setting. However, we must be better prepared to help these practices and patients navigate uncertain times where access to physician practices may be temporarily suspended. **The AMA recommends that both legislators and regulators consider the needs of non-hospital practices and patients when implementing new policies for pandemic response.** This may include, for example, financial assistance considerations, and acquisition and distribution of PPE, and other important considerations.

Moreover, logistical planning for public health emergency response must have a permanent home within the federal government. As the federal government engaged in acquisition and distribution of critical

medical supplies, such as PPE and ventilators, it became clear that expertise in supply chain management and logistics would play a critical role in the federal response to the COVID-19 pandemic. The AMA recommends that responsibility for coordination of these activities become part of a permanent role within the federal government, instead of part of a temporary task force where lessons learned are potentially lost after the end of the public health emergency. If responsibility for pandemic response supply chain and logistics rests with Federal Emergency Management Agency (FEMA), the AMA recommends creation of a permanent/formalized bridge to HHS to ensure coordination of the two agencies during times of need.

Interagency coordination must be improved by creation of permanent roles responsible for coordination between the major departments and agencies responding to public health emergencies. The AMA recommends that each agency with a role to play in public health emergency response have dedicated individuals or units that will be responsible for interagency coordination. These individuals or units should be permanently tasked with this responsibility so that they are able to respond rapidly to emerging threats. These roles should not be created on a temporary basis, or as part of a task force that is rapidly disbanded when the threat subsides.

PUBLIC HEALTH

CDC Public Health Emergency Preparedness (PHEP) Program (Question 11)

According to the [Trust for America's Health](#) (TFAH), the response systems, personnel, and infrastructure that states require to respond to public health emergencies like COVID-19 would not exist in most states without PHEP funding. TFAH notes that since 2002, the PHEP program has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to prepare for and rapidly respond to public health threats. However, through both real funding decreases and inflation, funding for the PHEP Program has been reduced 48 percent since FY2003. Increased federal funding is crucial to maintaining state, local and territorial public health preparedness capacity. The AMA supports the recommendation by TFAH and the Association of State and Territorial Health Officials (ASTHO) that the PHEP Program needs \$824 million in funding. This level of funding would:

- Strengthen the nation's readiness to protect the public from future dangers caused by catastrophic emergencies like a pandemic as well as smaller regional emergencies.
- Help restore capacity at health departments impacted by budget cuts and address gaps identified in the PHEP capabilities operational readiness review process, in areas such as risk communications and medical countermeasures distribution.
- Modernize data systems to enhance surveillance systems, data management, and sharing and analysis of disease trends.
- Build the Laboratory Response Network (LRN) and CDC and public health expertise and capacity for radiological and nuclear events. There is currently no public health laboratory capacity outside of CDC for this kind of testing and only limited throughput at CDC's lab.
- Advance biological and chemical laboratory capacity in states to keep up with current technologies and threats.
- Support field staff in additional states, who are highly trained personnel who can help jurisdictions build their disease surveillance and response capability.

Chronic Disease (Questions 12 and 13)

Chronic diseases have had a tremendous impact on COVID-19's worst outcomes. Two areas are of particular concern to AMA are the impact on groups that have been historically marginalized and the impact on chronic disease management and primary clinical care.

One in four U.S. adults have two or more chronic conditions⁵ while more than half of older adults have three or more chronic conditions. Some populations, including those with low socioeconomic status and those of certain racial and ethnic groups, including Black, Latinx, and Native American, have a disproportionate burden of chronic disease and subsequently had higher rates of complications and hospitalizations and mortality associated with COVID infection.⁶

COVID-19's infectious nature resulted in many Americans' delaying much needed care for a chronic disease and with many health systems shutting down in-person clinical care while establishing protocols for telehealth visits. The epidemic of chronic disease is expected to worsen as a result of the COVID-19 pandemic, and in turn this worsening epidemic of chronic disease serves as a threat to America's pandemic preparedness.

One complexity of chronic disease prevention and management is that chronic conditions often do not exist in isolation.⁷ Additionally, people with chronic diseases need a combination of clinical and community support through programs like those offered by the CDC, which provide evidence-based interventions that clinical teams can leverage. One of the barriers to greater program effectiveness would be for the federal government to remove any structural barriers that create silos. These silos result in inconsistent program innovations. For the past several years, the AMA has partnered with the CDC's Million Hearts Program and Division of Diabetes Translation on addressing uncontrolled hypertension and preventing type 2 diabetes, respectively. Examples that have effective interventions that are not leveraged by other CDC divisions include the Office on Smoking and Health, which has a sophisticated media campaign and media resource center for use by partners that other CDC divisions are not replicating, and the Division of Diabetes Translation, which oversees the National Diabetes Prevention Program (NDPP). The NDPP creates access to an intensive lifestyle-change program intended to prevent type 2 diabetes. This program or similar interventions may be effective for preventing multiple chronic diseases, but the program infrastructure/approach has not been applied outside of this division.

These programs are designed to have an impact on chronic diseases associated with lifestyle behaviors exacerbated by social drivers. The Community Guide to Preventive Services is the only mechanism in place that provides a link between the offerings of Federal agency programs. There should be a structured process for each agency to collaborate, cross-promote, and when appropriate, combine programs to have a greater impact on chronic disease prevention and management. This might be in the form of an interactive

⁵ Tinker A. How to Improve Patient Outcomes for Chronic Diseases and Comorbidities. [(accessed on 30 December 2017)]; Available online: <http://www.healthcatalyst.com/wp-content/uploads/2014/04/How-to-Improve-Patient-Outcomes.pdf>.

⁶ Centers for Disease Control and Prevention. Risk for COVID-19 infection, hospitalization, and death by race/ethnicity. Updated March 12, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

⁷ Raghupathi W, Raghupathi V. An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach. *Int J Environ Res Public Health*. 2018;15(3):431. Published 2018 Mar 1. doi:10.3390/ijerph15030431.

website that facilitates combining evidence-based programs. A series of webinar and toolkits to assist clinical teams in designing treatment plans that include prevention programs could be a companion to the web portal. These are just examples of how agencies can pool resources, but more integration and expansion of existing programs need to also be addressed.

Lifestyle behaviors are major long-term causes of the development of chronic diseases. The resultant disease often comes after months or years of poor behaviors. Lifestyle behaviors are often linked to social and structural systems that encourage and incentivize the behavior rather than making the healthier option the default. The notion that health behaviors are driven solely by personal choice has been refuted by numerous research studies.^{8,9,10} Health behaviors, such as smoking, diet, and physical activity, are often driven by social and economic factors that are more influential than health behaviors alone on improving health outcomes.¹¹

People with fewer high-risk lifestyle behaviors live longer, have fewer chronic diseases and their associated adverse health outcomes.¹² Solutions to this are far from simple, but these solutions—like the impact of poor lifestyle behaviors—are additive. The more incentives or opportunities there are to “choose” a healthier path, the greater the reward (i.e., improved health). Addressing lifestyle behaviors in the worsening epidemic of chronic disease requires a multi-pronged approach that supports programs and policies that target the behavior (e.g., smoking cessation programs, sugary drink taxes) and the social determinants or drivers that promote the behavior (e.g., nutritious food access and affordability, access to outdoor spaces/parks, etc.).

The CDC and other federal agencies, including those not traditionally associated with health like the U.S. Department of Housing and Urban Development and the U.S. Department of Transportation, have the ability and the authority to improve social drivers and advance programs and policies at the community level. While small demonstration grants provide the needed real-world experiments, it is the state and local health departments that shoulder the implementation burden. Improving the public health infrastructure is needed to drive change at the community and local levels.

Social Determinants of Health (Question 14)

The AMA recognizes racial and ethnic health inequities as a major public health problem in the U.S. and as a barrier to effective medical diagnosis and treatment. The elimination of racial and ethnic inequities in health care is an issue of highest priority for the AMA, and we advocate that health equity—defined as optimal health for all—be a goal for the U.S. health system. In order to address social determinants of health (SDOH) and health inequities, the AMA has created a [Center for Health Equity](#) whose mission is

⁸ Short SE, Mollborn S. Social Determinants and Health Behaviors: Conceptual Frames and Empirical Advances. *Curr Opin Psychol.* 2015;5:78-84. doi:10.1016/j.copsyc.2015.05.002.

⁹ Cha E, Crowe JM, Braxter B, Jennings B. Understanding How Overweight and Obese Emerging Adults Make Lifestyle Choices, *Journal of Pediatric Nursing.* Issue 6, November–December 2016, Pages e325-e332.

¹⁰ Leichter H. “Evil Habits” and “Personal Choices”: Assigning Responsibility for Health in the 20th Century, *The Milbank Quarterly*, Vol. 81, No. 4, 2003.

¹¹ <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

¹² Nyberg ST, Singh-Manoux A, Pentti J, et al. Association of Healthy Lifestyle With Years Lived Without Major Chronic Diseases. *JAMA Intern Med.* 2020;180(5):760–768. doi:10.1001/jamainternmed.2020.0618.

to strengthen, amplify, and sustain the AMA’s work to eliminate health inequities—improving health outcomes and closing disparity gaps—which are rooted in historical and contemporary injustices and discrimination.

Physicians are a vital component of our nation’s health care infrastructure, and the COVID-19 pandemic has highlighted the health inequities which continue to exist in our nation and impact the most vulnerable in our communities. To advance health equity, we must promote greater diversity among medical school applicants and enrollees. We know from research and experience that all patients, but particularly those from minoritized and marginalized communities, benefit from a diverse physician workforce and are even likely to see improved outcomes. Studies show that patient satisfaction and health outcomes are improved when health providers and their patients have concordance in their racial, ethnic, and language backgrounds. Diversity also enhances students’ learning environments and fosters greater innovation. Federal investments to increase the number and diversity of physicians are profoundly needed. When the number of active physicians is delineated by race, and then overlaid with U.S. Census Bureau data broken down by race, one can easily see the need to focus on developing a more diverse physician workforce. Specifically, while Hispanic Americans make up 18 percent of the U.S. population, they make up only 5.8 percent of active physicians in the U.S., and while Black Americans make up 13 percent of the U.S. population, they make up only 5 percent of active physicians in the U.S.^{13,14} As a result, the AMA strongly urges Congress to provide the appropriate funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the U.S. population.

Additionally, the AMA has identified several other Federal policies and strategies which should be established to further strengthen efforts to address SDOH, including, but not limited to: removing barriers to access to health insurance coverage and care (including expanding access to insurance subsidies to promote purchasing of health insurance coverage offered on the Affordable Care Act (ACA) exchanges and the expansion of Medicaid); directing the Centers for Medicare & Medicaid Services (CMS) to incorporate SDOH data and provide support for addressing patients’ SDOH in Medicare and Medicaid payment systems and alternative payment models; funding efforts to address SDOH along with identifying and overcoming existing barriers to implementing SDOH-related programs; and increasing funding to community-based organizations to strengthen infrastructure and capacity to coordinate and collaborate with patients and health care organizations.

Congress is working to improve the impact of SDOH on patient care and **the AMA supports two crucial pieces of legislation that offer federal solutions to address these non-health care factors, specifically [H.R. 2503](#), “the Social Determinants Accelerator Act of 2021,” and [S. 509](#), “the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act.”** H.R. 2503 would provide \$25 million in planning grants to state, local, and tribal governments to design “social determinants accelerator plans” to improve the health and well-being of individuals, especially those participating in the Medicaid program. The legislation also stipulates that 20 percent of the funding be reserved for policy plans that assist rural populations. These plans could be targeted at a group of high

¹³ <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>.

¹⁴ <https://www.census.gov/quickfacts/fact/table/US/PST045221>.

need Medicaid patients, such as homeless individuals, older workers with arthritis, nursing home patients, or mothers diagnosed with post-partum depression, as well as identify key outcomes to be achieved through improved coordination of health and non-health services and use of evidence-based treatments.

The social determinants accelerator plans also would include provisions for linking data across programs measuring the impact of the new approach on the health of participants and the return-on-investment for taxpayers. An underlying goal of the accelerator plans is to develop ways to more effectively identify and utilize existing programs and authorities to address SDOH. To assist with this crucial task, the bill requires HHS to establish and convene the Social Determinants Accelerator Council, an inter-agency technical advisory council on SDOH. The technical assistance provided by the task force includes helping state, local, and tribal governments better leverage unknown or underutilized programs, along with developing rigorous program evaluation guidelines.

In addition, S. 509 would require the Secretary of HHS to award grants to states, on a competitive basis, to support the establishment of new or enhancement of existing community integration network infrastructure to connect health care providers to social services organizations in order to help patients overcome longstanding accessibility challenges related to various SDOH (e.g., food, housing, child development, job training, transportation, etc.). This federal effort to enhance communication between physicians and community social services infrastructure will undoubtedly improve patient outcomes. The AMA is working with the bill's sponsors to ensure that the data is protected by privacy and security standards.

Bolstering Confidence in Public Health Institutions (Question 15)

The AMA believes that growing distrust of public health departments and officials is directly related to the extreme politicization of COVID-19 and the resultant mischaracterizations of the pandemic, as well as the rapid and widespread dissemination of COVID-19 misinformation and disinformation. Concerns have been expressed by our members about the interference with the scientific guidance put out by the CDC and the impact that has had on both public trust and public willingness to follow evidence-based recommendations. Concerns have also been raised about collaboration and the lack of consistent messaging across the federal, state, territorial, local, and tribal levels. At the state level, in some jurisdictions, public health leaders may have believed that requiring certain public health measures was the right thing to do (e.g., requiring masks or vaccines for returning college students or primary school and secondary school-aged students), but they would not say it because the governor was not in favor of it. Unfortunately, some of the politicization of the COVID-19 pandemic has originated from Congress itself, with some members themselves engaging in the spread of misinformation and disinformation, as well as harsh criticism of our country's public health institutions. Public health officials need to have the authority they need to lead and make evidence-based decisions including emergency declarations. This includes defending against efforts by legislatures to strip that power away or efforts by governors to countermand evidence-based recommendations. Public health is not in a position, on its own, to be able to defend against the curtailing of public health authorities.

We encourage Congress to explore appropriate methods of limiting online spread of misinformation and disinformation about COVID-19 and any future pandemic diseases. Nowhere does blatantly false and dangerous misinformation/disinformation spread more quickly than on social media, where spread of this type of information happens largely unchecked until it is too late. Additionally, Congress should consider what efforts may be taken to limit the spread of the same type of information by more mainstream media

sources. While the AMA encourages healthy debate and dissent over critical issues, in the instance of COVID-19 the dangerous spread of blatantly false information regarding the seriousness of COVID-19 and regarding mitigation measures such as face masks and in particular, COVID-19 vaccines, has clearly led to completely preventable serious illness and death in tens of thousands of Americans, particularly during the most recent Omicron wave. Until Congress commits to the broad, bipartisan support of evidence-based actions by our public health officials, the U.S. will likely continue to suffer from broad distrust of these agencies and their recommendations, with cascading effects felt by state and local officials and detrimental impacts on Americans in those communities.

Vaccine Hesitancy and Impact of COVID-19 on Preventive Vaccination (Question 16)

Unfortunately, there has been increasing vaccine refusal and hesitancy over the past several years in the U.S. In many cases, this lack of confidence has surrounded established vaccines despite long track records of safe and effective use in the population. With vaccine hesitancy on the rise, as well as the ongoing spread of medical misinformation and disinformation related to COVID-19, it should not be surprising that there has been, and continues to be, vaccine hesitancy related to the vaccines available for COVID-19.

The AMA has been very concerned about the decline in vaccination against vaccine preventable diseases for both children and adults. It is vital that administration of routine vaccines occur on time to prevent certain communicable diseases. These routine vaccinations induce long-term immunity for many infectious diseases while also preventing cervical, oropharyngeal, and other cancers. Vaccination also reduces the transmission of infections within communities.

But recently published research sheds new light on how the COVID-19 pandemic has disrupted some of those routine vaccinations, as parents and their children not only stayed home—they stayed away from the doctor. The *JAMA Pediatrics* [study](#), “Association of the COVID-19 Pandemic With Routine Childhood Vaccination Rates and Proportion Up to Date With Vaccinations Across 8 US Health Systems in the Vaccine Safety Datalink,” found that vaccine-administration rates were significantly lower across all pediatric age groups as the pandemic first surged in the U.S. The proportion of those who were up to date on their routine vaccinations was lower for most age groups evaluated in September 2020 compared to September 2019. Coverage also varied by race and ethnicity. The study found there were declines in vaccinations at the onset of the pandemic through May 2020 as people were encouraged to stay home and delay nonurgent medical care. But lower vaccination rates persisted in most age groups through September 2020.

The authors also evaluated the percent of children up to date for routine immunizations by specific ages, again comparing 2020 data to 2019 data. For example, only 74 percent of infants turning 7 months old in September 2020 were up to date on their vaccinations, a drop from 81 percent in September 2019. And just 57 percent of infants who hit the 18-month mark in September 2020 were up to date, down from 61 percent the year before. The proportion of children up to date for routine vaccinations was lowest among Black children, with inequities more pronounced in the 18-month-old group.

Even after measures discouraging routine outpatient care were relaxed, playing catch-up on routine vaccinations has lagged. The study notes that “Disruptions to the timing of vaccine appointments in early infancy can lead to substantial delays in completion of vaccine series because of the required minimum intervals between vaccine doses and the need for additional health care visits to receive missed vaccines.”

Vaccine coverage among Black infants was lower than in other racial and ethnic groups. There are many reasons for these inequities, which have structural, logistical, cultural, and other variables contributing to low vaccination rates. Health system- and community-level interventions are needed to address these inequities. These interventions should be used to support on-time vaccination for children, especially for those in traditional underserved and marginalized communities. It is also important to have vaccine mandates prior to school entry, which is key for increasing vaccine uptake across populations while also reducing vaccine inequities.

Vaccinations are critical components of routine health care for adults. They provide protection against severe illness, disability, and death from 15 different infectious diseases such as influenza, pneumococcal disease, herpes zoster (shingles), hepatitis A, hepatitis B, HPV-related cancers, tetanus, and pertussis (whooping cough). Time and again, [vaccines have demonstrated their value](#) in maintaining the health of individuals and their communities; vaccines are among the most effective and cost-effective preventive health interventions available. Despite the tremendous benefit of vaccines, most adults in the U.S. are missing one or more routinely recommended vaccines. As with childhood vaccinations, racial and ethnic disparities in adult vaccination coverage are also prevalent and have widened for some vaccines in recent years.

Education and outreach campaigns are critical for reversing both the short-term decline due to the COVID-19 pandemic and the long-term decline in vaccinations against vaccine preventable diseases. The AMA encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates and urges Congress to increase funding for such campaigns. We regularly participate in the CDC's vaccination awareness and education campaigns for both children and adults and most recently, participated in the National Adult and Influenza Immunization Summit's Call to Action to Protect All Adults from Vaccine-Preventable Disease and Disability.

The AMA also encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines, supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children, encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them, and promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science. **The AMA urges Congress to provide increased funding to CDC to enable more extensive public vaccination education and awareness campaigns.**

Public Health Laboratory Capacity (Question 17)

The AMA does not necessarily agree that state public health laboratory capacity and surveillance activities were "insufficient." Unfortunately, public health laboratories were never going to be able to manage the sheer volume of testing and surveillance activities that have been required to help manage COVID-19 testing and surveillance during the course of the pandemic. While public health departments, including laboratories, are consistently in need of appropriate funding, we would strongly encourage Congress and federal departments and agencies to consider developing testing and surveillance plans that can utilize partnerships with additional laboratories, such as those at academic centers, hospitals and health systems, and private laboratories to expand capacity and capabilities. When encountering pandemic

disease that spreads as rapidly as COVID-19, we must consider utilizing every existing resource to meet testing needs.

Specific problems that need to be addressed prior to facing the next epidemic/pandemic include early issues with CDC testing capabilities and requirements that only CDC tests for SARS-CoV-2 be used. Many laboratories could have quickly and easily stood up testing capabilities for the SARS-CoV-2 virus and should have been utilized in close collaboration with CDC and local public health laboratories immediately upon discovery of transmission within the U.S. Additionally, early on stringent requirements for test validation and authorization from the FDA hindered the ability of labs in academic centers, hospitals, and private settings from quickly standing up and utilizing this additional critical testing capacity. Congress and federal agencies need to ensure there are specific plans in place to immediately utilize these additional laboratory sites, particularly where these accredited laboratories have significant experience in developing validated laboratory developed tests. Requirements related to validation data and FDA authorization need to be minimal and nimble enough to ensure they do not hinder development of additional testing capacity.

In addition, many supply chain issues and component shortages plagued testing capacity early in the pandemic and throughout surges over the last two years. Going forward Congress should work with federal agencies to develop plans for additional manufacturing capacity for critical testing supplies, including identifying domestic manufacturing partners and utilizing public-private partnerships to quickly ramp up production of components subject to shortage.

The U.S. can also make improvements in its surveillance capabilities, particularly when it comes to genetic sequencing of a currently circulating virus to quickly identify potential new variants of concern. The COVID-19 pandemic has shown that these types of surveillance capabilities were less than adequate in the U.S., although capabilities have ramped up quickly in the second year of the pandemic as new variants of concern became an increasing issue throughout the second year of the pandemic.

Lastly, federal departments and agencies must ensure collaboration, communication, and transparency about testing supply chain issues with all laboratory stakeholders. While high-volume national commercial laboratories such as LabCorp and Quest play an unquestionably significant role in pandemic testing, several other testing sites, such as those within academic centers, hospital/health systems, and community laboratories, also played a very critical role in providing testing services. Unfortunately, communication with these testing settings was limited early on in the pandemic, leaving those laboratories unaware of shortages and with questions about how best to create workarounds to keep testing services available. We strongly recommend Congress and federal agencies work together to develop better strategies to ensure communication with all stakeholders about critical testing issues throughout the course of the pandemic.

Native American Health Care (Question 19)

The AMA strongly urges the federal government to provide sufficient funds to support needed health services for American Indians. The federal government has consistently underfunded the IHS. For example, in 2018, IHS spending for medical care per user was only \$3,779, while the national health care spending per capita was \$9,409—an astonishing 60 percent difference. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Tribal

communities. Without funding increases, Tribes face an impossible task in efforts to eliminate health disparities.¹⁵

The AMA urges Congress to ensure that all of the facilities that serve Native Americans under the IHS be adequately funded to fulfill their mission and their obligations to patients and providers. The AMA implores Members of Congress to take all necessary action to immediately restore full and adequate funding to the IHS. We believe the IHS should not be treated more adversely than other health plans in the application of any across the board federal funding reduction.

Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those IHS facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. Additionally, compensation for IHS physicians must be increased to a level competitive with other Federal agencies and nongovernmental service; and consideration should be given to increased compensation for service in remote areas.

The AMA also strongly supports those federal bills which aim to improve the health of and health-related services provided to American Indians. COVID-19 has amplified health inequities in American Indian communities because of underfunded and under-resourced health systems, limited access to health services, poor infrastructure, and underlying health disparities. For example, American Indian or Alaska Native individuals were 3.5 times more likely to be hospitalized for the COVID-19 virus.¹⁶ We can, and we must do better to improve health outcomes in American Indian communities.

Maternal Health (Question 21)

The reasons for the overall increase in pregnancy-related mortality are complex and multifactorial, and the CDC highlights “considerable racial/ethnic disparities in pregnancy-related mortality.”¹⁷ These disparities reflect the unique nature of maternal health at the intersection of race and gender. In addition, according to the CDC, for every pregnancy-related death, an average of three to four contributing factors were identified, at multiple levels, including community, health facility, patient/family, provider, and system.¹⁸

Postpartum care is essential not only for monitoring the health of women after the acute major medical event of childbirth, but also for managing women’s chronic conditions, promoting overall health and

¹⁵ <https://www.nihb.org/covid-19/wp-content/uploads/2021/03/NIHB-2021-Legislative-and-Policy-Agenda.pdf>.

¹⁶ <https://hub.jhu.edu/2021/10/11/map-covid-19-impact-american-indian-population/>.

¹⁷ Pregnancy Mortality Surveillance System. Centers for Disease Control and Prevention (CDC). November 25, 2020. Available at: <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

¹⁸ Petersen EE, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019. DOI: <http://dx.doi.org/10.15585/mmwr.mm6835a3> Available at: <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>.

well-being, and serving as a link for vulnerable women to the health care system.¹⁹ The “fourth trimester,” (the first 12 weeks postpartum) can present considerable physical and behavioral health challenges. Nearly 70 percent of women describe at least one physical health problem during the 12-month postpartum period, and 45 percent of these problems are deemed to be moderate to severe. For example, during the 12-month postpartum period, women may experience urinary incontinence, fecal incontinence, perineal or genital pain, and impaired sexual function. In addition to these physical complications, maternal behavioral health conditions (including depression, anxiety, and other illnesses) are the most common complications during pregnancy and 12 months postpartum, affecting one in five women.²⁰

More than half of pregnancy-related deaths occur after the birth of the infant.²¹ Specifically, and critical to policy decisions regarding postpartum care, support, and insurance coverage, approximately 16 percent of pregnancy-related deaths occurred between 1-6 days postpartum, 19 percent occurred between 7-42 days postpartum, and 24 percent occurred between 43-365 days postpartum.²² Nevertheless, approximately 40 percent of women do not attend a postpartum visit.²³ Critical barriers to obtaining postpartum care include lack of child care, inability to obtain an appointment, and limited understanding of the value of the visit. These barriers are even more challenging for patients with limited resources, decreasing attendance rates and contributing to disparities. Notably, 23 percent of employed women return to work within 10 days of giving birth, and an additional 22 percent return to work between days 10 and 42 postpartum. Only 14 percent of American workers—and only five percent of low-wage workers—have access to paid leave. As such, health insurance is critical to obtaining access to maternal health care, but maternity coverage under Medicaid (which covers nearly half of American deliveries) ends at 60 days postpartum.²⁴ While some women successfully transition to other sources of coverage, many are left uninsured shortly after a major medical event.²⁵

¹⁹ Elizabeth A Howell. Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clin Obstet Gynecol*. Author manuscript; available in PMC 2019 Jun 1. Published in final edited form as: *Clin Obstet Gynecol*. 2018 Jun; 61(2): 387–399. doi: 10.1097/GRF.0000000000000349. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/> and American College of Obstetricians and Gynecologists. Optimizing Postpartum Care. ACOG Committee Opinion Number 736. May 2018. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>.

²⁰ National Conference of State Legislatures. State Approaches to Ensuring Healthy Pregnancies Through Prenatal Care. April 15, 2021. Available at: <https://www.ncsl.org/research/health/state-approaches-to-ensuring-healthy-pregnancies-through-prenatal-care.aspx>.

²¹ American College of Obstetricians and Gynecologists. Optimizing Postpartum Care. ACOG Committee Opinion Number 736. May 2018. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>.

²² Davis NL, et. al. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019. Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf.

²³ American College of Obstetricians and Gynecologists. ACOG Postpartum Toolkit. Available at: <https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/2018-postpartum-toolkit.pdf>.

²⁴ MACPAC. Medicaid’s Role in Financing Maternity Care: Fact Sheet. January 2020. Available at: <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>.

²⁵ Emily Eckert. Preserving the Momentum to Extend Postpartum Medicaid Coverage. *Womens Health Issues*. 2020 November-December; 30(6): 401–404. Published online 2020 Sep 9. doi: 10.1016/j.whi.2020.07.006. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7480528/>.

Access to affordable, comprehensive health care and insurance throughout a woman's life is critical to achieving optimal maternal health outcomes, yet systemic barriers, including racism and sexism, and inequities in SDOH impact income levels and insurance status. Two key provisions of the ACA contributed to insurance coverage gains: Medicaid expansion to adults with incomes of up to 138 percent of the federal poverty level (FPL) in some states, and the availability of subsidized insurance coverage through Marketplace plans for people with incomes of up to 400 percent of FPL. The ACA Medicaid expansion has been found to be associated with reductions in maternal mortality.²⁶ Expanding Medicaid reduced uninsurance among women of reproductive age overall, and specifically, it reduced uninsurance preconception, during pregnancy, and postpartum. Expanding Medicaid led to improved access to care, increased use of health services, and better self-reported health among women of reproductive age. Insurance preconception and postpartum improves women's health in multiple ways, including increasing opportunities for managing chronic conditions and family planning. Expansion states also experienced significant reductions in Black–White disparities in adverse birth outcomes.²⁷ Despite these gains, nearly 12 percent of new mothers were uninsured in 2016 to 2018.²⁸ Moreover, in 2015 to 2017, approximately 29 percent of new mothers experienced a change in insurance status between delivery and six months postpartum. While the ACA provided incentives for states to expand Medicaid, as of this writing, 12 states have chosen not to do so.²⁹ In addition, immigration status prevents some women from qualifying for publicly subsidized health insurance. For women with higher incomes, a steep “subsidy cliff” makes premium payments for Marketplace plans far more expensive as soon as income exceeds 400 percent FPL, potentially preventing women from obtaining affordable insurance.³⁰ This can be especially challenging when women unexpectedly lose access to employer-sponsored insurance, as has frequently been the case during the COVID-19 pandemic. Coverage options for women with lower incomes are even more complicated. In all but two states, the income thresholds for Medicaid and State Children's Health Insurance Program (CHIP) qualification are higher for pregnancy-related coverage than for nonpregnant parents or other adults. As a result, women who were insured by Medicaid or CHIP due to their pregnancy status, but who lose access to pregnancy-related coverage at 60 days postpartum, experience insurance churn or may not have an affordable insurance coverage option.³¹

²⁶ Emily M. Johnston, et. al. Post-ACA, More Than One-Third Of Women With Prenatal Medicaid Remained Uninsured Before Or After Pregnancy. *Health Affairs*. April 2021. doi: 10.1377/hlthaff.2020.01678. Available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01678>.

²⁷ Joia Crear-Perry, et. al. Social and Structural Determinants of Health Inequities in Maternal Health. *Journal of Women's Health*. February 2022. doi: 10.1089/jwh.2020.8882. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8020519/>.

²⁸ Johnston et. al. Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care through a Postpartum Medicaid/CHIP Extension. Urban Institute. January 2021. Available at: https://www.urban.org/sites/default/files/publication/103560/closing-postpartum-coverage-gaps-and-care-through-postpartum-medicaid-chip-extension_2.pdf.

²⁹ KFF. Status of State Medicaid Expansion Decisions: Interactive Map. Jul 23, 2021. Available at: <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

³⁰ Daniel McDermott. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums. KFF. March 15, 2021. Available at: <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-house-covid-19-relief-proposal-on-marketplace-premiums/>.

³¹ Johnston et. al. Closing Postpartum Coverage Gaps and Improving Continuity and Affordability of Care through a Postpartum Medicaid/CHIP Extension. Urban Institute. January 2021. Available at: https://www.urban.org/sites/default/files/publication/103560/closing-postpartum-coverage-gaps-and-care-through-postpartum-medicaid-chip-extension_2.pdf.

In states that expanded Medicaid, some women will be able to continue Medicaid coverage postpartum. For other women, premium tax credits could help them purchase subsidized insurance through the Marketplace. However, Marketplace plans may require women to incur additional out-of-pocket costs and/or change physicians, and women recovering from giving birth and caring for an infant may not undertake the effort of finding a suitable Marketplace plan. In states that have not expanded Medicaid, adult Medicaid eligibility is typically below the FPL. Low-income residents in these states fall into a “coverage gap,” having incomes that are too high to qualify for their state’s Medicaid but that are below the FPL, which is the minimum threshold for subsidized Marketplace coverage. When women lose pregnancy-based Medicaid, they may not have an affordable coverage option. Additionally, six states build on Medicaid’s foundation and offer CHIP coverage to pregnant women at higher income levels.³² Accordingly, to protect new mothers in these six states, policies to extend public coverage until 12 months postpartum must reference both Medicaid and CHIP.

To increase affordable access to care, limit patient churn, and promote continuity and coordination of care, **the AMA strongly supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy.** The AMA also supports expansion of Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. Additionally, the AMA supports 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and the development of a mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. Moreover, the AMA advocates for adequate payment from all payers for the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and behavioral health care. Finally, our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.

The Health Resources and Services Administration’s (HRSA’s) Maternal and Child Health Bureau describes the current paradigm for prenatal care as including 15 face-to-face visits between the patient and her maternal health care team, which provide critical medical services, risk assessments, patient education, and opportunities to build trust.³³ However, many patients, both in rural and urban communities, face personal barriers (e.g., work, childcare, transportation, education, culture, or language), health system barriers (e.g., limited hours of operation, or lack of services), and environmental barriers (e.g., location or connectivity) that prevent them from attending some or all of their planned prenatal visits. HRSA’s Remote Pregnancy Monitoring Challenge strives to reduce these barriers by supporting innovative technology-based solutions that help medical teams remotely monitor pregnant women, which can promote building trusting, ongoing relationships among patients and their medical teams and empowering women to make informed decisions about their care. The expansion of telehealth services during the COVID-19 pandemic has provided evidence of the potential benefits of telehealth and remote patient monitoring. For example, a recent study conducted at a hospital predominantly serving Medicaid patients found that access to virtual prenatal care for some of the standard prenatal appointments was associated with greater attendance rates compared with in-person appointments alone, and there were no

³² Maggie Clark. Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options. Georgetown University Health Policy Institute Center for Children and Families. November 2020. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf>.

³³ HRSA Maternal & Child Health. Remote Pregnancy Monitoring Challenge. Available at: <https://mchbgrandchallenges.hrsa.gov/challenges/remote-pregnancy-monitoring>.

deleterious outcomes among the women or infants participating in virtual prenatal care.³⁴ As such, additional resources should be allocated to Remote Pregnancy Monitoring and access to telehealth.

As outlined by the CDC, there are three essential sources of data on maternal mortality: (1) CDC's National Center for Health Statistics' National Vital Statistics System, (2) the CDC's Pregnancy Mortality Surveillance System, and (3) state and local Maternal Mortality Review Committees (MMRCs).³⁵ The data collected by each of these sources is not standardized—they apply different definitions of maternal mortality, and they draw on different sources. In addition, there is no systematic ongoing data collection for population-based maternal morbidity in the U.S.³⁶ The source of data for CDC's national SMM estimates is the Nationwide Inpatient Sample. The Pregnancy Risk Assessment Monitoring System also provides insights into health problems among mothers and babies. Contributing to data challenges is the fact that while patient identity data such as race, ethnicity, and language is essential to understanding sources of disparities, patients may be hesitant to divulge private information, especially if they do not know how their data may be used.³⁷ Moreover, for these data to be useful, they must elicit information that accurately reflects the diversity within racial and ethnic categories, and they must be collected and reported consistently. Data collection and reporting legal requirements and policy must also include anti-discrimination protections to ensure that the collection of race, ethnicity, and language data is used to reduce, rather than create or exacerbate, inequities that harm individuals and populations.

The AMA also urges the development and adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:

- informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
- carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and

³⁴ Elaine L. Duryea, et. al. Comparison Between In-Person and Audio-Only Virtual Prenatal Visits and Perinatal Outcomes. *JAMA Netw Open*. April 14, 2021. doi:10.1001/jamanetworkopen.2021.5854. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2778558?guestAccessKey=7f4883aa-a205-4ed2-a29a-e7b4f17dce60&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jamapediatrics&utm_content=olf&utm_term=041921.

³⁵ Pregnancy Mortality Surveillance System. Frequently Asked Questions. Centers for Disease Control and Prevention (CDC). November 25, 2020. Available at: <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#faqs>.

³⁶ Andreea A. Creanga, et. al. Maternal Mortality and Morbidity in the United States: Where Are We Now? *J Womens Health (Larchmt)*. 2014 Jan 1; 23(1): 3–9. doi: 10.1089/jwh.2013.4617. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3880915/>.

³⁷ Consensus Statement. Elizabeth A. Howell, et. al. Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle. *Obstetrics & Gynecology*: May 2018 - Volume 131 - Issue 5 - p 770-782 doi: 10.1097/AOG.0000000000002475. Available at: https://journals.lww.com/greenjournal/Fulltext/2018/05000/Reduction_of_Peripartum_Racial_and_Ethnic.4.aspx.

- lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

Additionally, the AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., MMRCs and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

Bolstering Public Health Infrastructure (Question 22)

In a series of recent interviews with public health and physician experts, the AMA identified eight major gaps or challenges in the U.S. public health infrastructure. Several of these have been addressed above in previous responses. This section of our comments will focus on additional critical issues.

Lack of Consistent, Sustainable Public Health Funding

Public health organizations have warned for years that their ability to keep the population safe from disease and public health emergencies is constrained by the lack of dedicated and sustained funding. This is a challenge affecting the entire public health system. Funding for public health is not consistent or sustainable. In the past 20 years, the nation has responded to every public health crisis with temporary funding measures that have not provided state and local public health agencies with the people and the tools needed to build enduring programs and infrastructure which address the population's health and adequately prepare for or prevent future emergencies. Shoring up the system will take years of consistent effort by public health officials and policymakers. Systems and administrative capabilities to distribute, manage, and oversee spending quickly, adequately, and equitably are lacking.

Strong and consistent funding levels are necessary for our public health system to respond to everyday health needs, sustain hard-fought health gains, and prepare for and prevent unexpected public health emergencies. Consistent and sustainable funding is needed not just for public health programs, but also for foundational capabilities (i.e., communication and information technology). Similar to the way that the FEMA is consistently funded to prepare for and respond to "unexpected crises" regardless of whether they occur, public health needs a strategy to fund for the long-term future of our population rather than focusing on the emergency of the day and after-the-fact.

The AMA urges Congress and responsible federal agencies to establish set-asides or stable funding to states and localities for essential public health programs and services, provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs. The AMA also urges support for the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion.

The AMA recognizes the importance of flexible funding in public health for unexpected infectious diseases to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas.

Workforce Shortages

There is a growing public health workforce shortage at the local, state, and federal levels. Within the next few years, state and federal public health agencies could lose up to half of their workforce to retirement and to the private sector. Due to local and state budget crises and federal budget cuts, the potential for a shortage of highly skilled public health professionals has become more immediate and severe in scope. In addition, governmental public health salaries are not competitive with other industries. Recent public health graduates are opting for careers in other industries. Public health agencies struggle to attract and retain top talent because they cannot afford to pay them salaries comparable to the private sector.

To strengthen the workforce, the visibility of public health as a potential career choice needs to be raised and promoted as a valuable component to keeping populations healthy. In addition, providing competitive salaries would help attract talent, as would [student debt reduction](#) or elimination programs and [loan repayment programs](#), including through the [National Health Service Corps](#). The public health workforce is aging and efforts to recruit young talent are direly needed. The AMA urges Congress to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program, strengthening of the Commissioned Corps of the U.S. Public Health Service, and expanding preventive medicine residency training programs.

Antiquated Data Systems

Syndromic surveillance by public health authorities is critical to pandemic response and ensuring coordination of medical resources across the country to leverage the greatest and most equitable level of care possible for all patients. Public health experts have emphasized to us the importance of prioritizing transmission of information to public health officials at the state and local levels since these officials urgently need data to make decisions for the general public. Absent such surveillance and other types of data collection at all levels of government, it is difficult to know where virus “hot-spots” are occurring, and where testing and other resources need to be focused. This information is also important to pandemic recovery: for example, it helps to inform policymakers as the country lifts restrictions on physical distancing and as businesses, schools, and governments reopen. Unfortunately, issues with accurate, consistent, and complete data have been a continuing concern throughout the current pandemic, including on the number of cases, testing results (e.g., the CDC and many states combined statistics on diagnostic tests and antibody tests), hospitalizations, and deaths.

Public health data systems are outdated and in dire need of modernization. During the COVID-19 pandemic, many public health agencies did not have access to real-time data around testing results and incidence of infections and illness to efficiently respond to the emerging crisis. Health departments are often unable to access accurate, complete, and timely data to effectively surveil disease outbreaks and promote healthy communities. Many state and local public health departments rely on paper documents, phone calls, and faxes to communicate. Many also require manual input of data into systems with limited functionality. Consistency of demographic data collection has been particularly poor. Race and ethnicity data for infections, hospitalizations, and deaths have been missing, or slow to be published, in many states.

While financial investments were made to modernize the health care data infrastructure, this has not happened on the public health side. In health care, data is collected in the electronic health record (EHR) and despite requirements for such data to be reported to public health, it can be days and weeks before

public health is alerted. When public health receives case reports, they are often missing key information, including race and ethnicity data. Reports are also missing data elements like a patient's address, so public health cannot geo-locate or map the cases to determine if there is an outbreak occurring in a particular area. Case reports are also often missing a patient's phone number, which is needed to conduct interviews for contact tracing.

To make matters worse, public health department data and systems are siloed. They work independently of each other and do not have an easy way to share information across state lines or even, at times, between agencies within a given state, preventing them from efficiently supporting each other. Even with public health data modernization, data shared with public health agencies for review and action, will only be shared in accordance with applicable health care privacy and public health reporting laws. Improving antiquated data systems will overall improve data governance and security, as well as improve access to vital surveillance data.

Priorities for public health data modernization should include automating the reporting of clinical and laboratory data from clinical health area data systems to public health. The U.S. also needs to ensure interoperability among health care and public health as well as among core public health surveillance systems. Core pieces of the public health data infrastructure need to be modernized, such as the National Notifiable Diseases Surveillance System and the vital records systems which capture data from births and deaths annually and which can signal changes in trends, monitor urgent events, and provide faster notification of cause of death. It is also important to support modernization of our syndromic surveillance system so that public health receives data in real-time from hospital emergency departments and urgent care centers to maintain a pulse on emergency-type visits and how the health care system is being impacted by emerging syndromes.

The AMA recognizes that public health surveillance is a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats. Physicians play an important role in public health surveillance through reporting diseases and conditions to public health authorities. We support increased federal, state, and local funding to modernize the nation's public health data systems to improve the quality and timeliness of data and support electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from EHRs to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws. The AMA also supports increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the CDC and state and local health departments, as well as data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. Our AMA encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery.

SUPPLY CHAIN ISSUES

As you are aware, the intense global demand for test kits and testing supplies during the pandemic has significantly impacted access to tests at many locations where those tests are critical to the treatment of

The Honorable Richard Hudson
The Honorable Jim Banks
The Honorable Tom Cole
January 31, 2022
Page 23

seriously ill patients. While we appreciate the federal government's efforts to procure needed supplies, both domestically and abroad, there has been very little transparency about those supplies provided to laboratories in need. The AMA strongly recommends new requirements for transparency and clarity in the testing supply chain, including what is in shortage, what is available, when additional supplies may be expected, and quantities that may be expected so that laboratories can develop strategies to best deal with available supplies. This responsibility should be clearly delineated by Congress and ultimately housed in a single federal entity that is responsible for gathering all information on the supply chain and delivering that information to relevant stakeholders at the state and local levels.

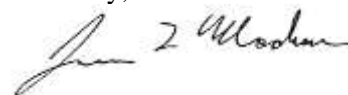
Recognizing that the COVID-19 pandemic has exacerbated many long-standing access and quality issues that threaten the resilience of our nation's health care supply chain, the AMA, along with the American Society of Anesthesiologists, American Society of Clinical Oncology, American Society of Health-System Pharmacists, and the United States Pharmacopeia worked together to craft recommendations to address gaps and deficiencies in the pharmaceutical and medical supply chains. Supply chain issues can adversely impact patient care by delaying treatment, worsening patients' health outcomes, or requiring patients to switch to non-optimal treatment regimens.

The broad recommendations are as follows:

- Incentivize advanced manufacturing technology and develop new continuous manufacturing technology for critical drugs and active pharmaceutical ingredients;
- Improve the function and composition of the Strategic National Stockpile;
- Improve multinational cooperation on supply chain resilience;
- Incentivize quality and resilience; and
- Replicate asks for critical drug manufacturing transparency and oversight for medical devices and ancillary supplies (e.g., PPE).

The complete recommendations can be found at <https://www.ashp.org/-/media/assets/news-and-media/docs/Healthcare-Supply-Chain-Recommendations>.

Sincerely,

A handwritten signature in cursive script, appearing to read "James L. Madara".

James L. Madara, MD