January 31, 2022

The Honorable Jim Banks
Co-Chair, Security Subcommittee
Healthy Future Task Force

The Honorable Tom Cole
Co-Chair, Security Subcommittee
Healthy Future Task Force

The Honorable Richard Hudson
Co-Chair, Security Subcommittee
Healthy Future Task Force

Dear Representatives Banks, Cole, and Hudson:

On behalf of the American Academy of Family Physicians and the American College of Physicians, we write in response to your request for information (RFI) on pandemic preparedness, public health, and supply chains and medical independence from China. We share your goal of taking the lessons learned thus far from the COVID-19 pandemic to improve our response to future pandemics and ultimately improve health outcomes for all.

Primary care physicians have been screening, diagnosing, triaging, and treating patients fighting COVID-19, while continuing to provide comprehensive care to patients with ongoing health care needs. Our member physicians also see firsthand the challenges and inequities as we continue to deal with the impact of the ongoing pandemic. We are pleased to provide feedback on the following questions in the RFI.

Pandemic Preparedness

What challenges does the Strategic National Stockpile face when distributing medical countermeasures to State and local partners? What steps can Congress take to fix these challenges?

Access to personal protection equipment (PPE) has been a continual challenge for primary care providers during the COVID-19 pandemic. Survey data shows that 1 in 3 primary care practices were consistently having trouble getting PPE in the first year of the pandemic.[1] During outbreaks and pandemics like COVID-19 and H1N1, our member physicians are on the frontlines screening, testing, and treating patients in outpatient and inpatient settings, often at great personal risk. It is imperative during public health emergencies that health care workers have adequate protection to decrease personal harm and the spread of disease. Congress should increase PPE production, stabilize the supply chain, and ensure that community-based clinicians are not excluded from PPE distributions from the Strategic National Stockpile.

Another issue is that children, pregnant women, and individuals with disabilities are often overlooked in disaster planning efforts, which can amplify their vulnerability during a disaster response or public health emergency. One example is the Strategic National Stockpile has only distributed adult-sized face masks during the COVID-19 pandemic. It is imperative that decisions regarding which products to keep in the Strategic National Stockpile include special populations such as children, pregnant or lactating individuals, and individuals with disabilities.

What changes to the vaccine development and approval process proved most beneficial to the timely development of COVID-19 vaccines? What changes might the federal government have made that would prove more beneficial still?

Pregnant and lactating individuals were excluded from initial 2019 COVID-19 vaccine trials, and therefore, data on the vaccine safety and efficacy in these populations has been delayed. Guidance

from public health officials has also been vague and at times conflicting. Long term vaccine safety data in pregnant and lactating individuals are understandably lacking, yet critically needed for counseling regarding not only the safety of the COVID-19 vaccines specifically but for mRNA vaccine platforms in general, as public perception regarding the safety of vaccines given in pregnancy hinges on providing high-quality information on neonatal and childhood outcomes. Current data collection efforts do have the opportunity to impact future mRNA and adenovirus-vector vaccine development efforts and public health campaigns. Federal agencies should prioritize the safe inclusion of pregnant and lactating individuals in the development of treatments and address the significant disparities across the country in the availability and accessibility of these treatments for patients that need them.

It is also critical to ensure that the current COVID-19 vaccines are updated as the virus continues to evolve and that our most at-risk populations, including pregnant people and those with underlying medical conditions, are included in the development of the vaccines. We encourage Congress and federal agencies to proactively plan for any future booster doses that may be needed to ensure that the public is fully protected and made aware of the need for these additional doses, as well as when and why they may be needed.

Public Health

How can Congress better utilize Community Health Centers (CHCs) to deliver high-quality, low-cost to Americans? How can Congress assist CHCs in providing improved care coordination services to patients?

Community Health Centers provide essential care to people in communities large and small, regardless of individuals' ability to pay. Health centers often are the only sources of care for people in rural and urban underserved communities. CHCs serve more than 28 million patients, 58% of whom are members of racial and ethnic minority groups and 68% of whom are at or below the federal poverty level.[2] Community Health Centers have been nimble and creative in the face of the pandemic, delivering care in new ways to meet patient needs during an extraordinary time. Data show that CHCs played a vital role in ensuring equitable access to and utilization of COVID-19 vaccines.[3] CHCs also play an important role in training the next generation of primary care physicians. It is vital that CHCs are financially and operationally stable, so they can continue to effectively provide patients with primary care, behavioral health, and dental services.

Congress should enact legislation to permanently allow Community Health Centers to provide telehealth services, including audio-only services, after the end of the PHE. Permanent Medicare coverage and sustainable payment for telehealth services provided by CHCs is essential for ensuring equitable access for low-income, rural, and other medically underserved communities. During the COVID-19 pandemic, 95% of CHCs used audio and video telehealth for medical services and 90% used it for behavioral health services.[4] Both patients and CHCs have benefitted immensely from the increased telehealth flexibilities, which have allowed health center providers to care for more vulnerable patients and improve their existing patient relationships.

How can Congress, CDC, and other relevant federal agencies, better address lifestyle choices that lead to chronic illness and promote prevention strategies?

Primary physicians are uniquely positioned to meet patients "where they are" and may be most effective in encouraging prevention measures, including being physically active and having a good diet. They are also well positioned to connect patients with community-based resources (social/mental health services and programs) to address social determinants of health. States with higher ratios of primary care physicians have lower smoking rates, lower obesity rates, and higher seatbelt use compared to states with lower ratios.[5, 6] Further, Medicaid-enrolled children who have

access to high-quality, timely, family-centered primary care have experienced both lower nonurgent and urgent emergency department utilization rates.[7]

We support proposals to eliminate the patient cost-sharing associated with chronic care management across public and private insurance. Evidence-based, patient-centered solutions must enable people living with serious chronic conditions to have affordable access to needed care throughout the year. Waiving cost-sharing requirements would increase coordination of care for those patients with the greatest health care needs.

Research shows that the increased use of high deductible health plans (HDHPs) is associated with delays in care, testing, and treatment that can lead to avoidable disease progression. We urge passage of the *Chronic Disease Management Act* (H.R. 3563), which will allow HDHPs to provide patients with access to certain chronic care services and treatments with no cost sharing before meeting their deductible. Additionally, we urge passage of the *Primary and Virtual Care Affordability Act* (H.R. 5541), which gives employers and health plan sponsors the flexibility to waive the deductible for primary care and telehealth services through December 31, 2023, for patients covered by HDHPs.

Access to primary care is proven to produce better health outcomes, increase evidence-based prevention interventions, and reduce health care costs.[8] The pandemic has highlighted that the current fee-for-service model is an outdated structure to meaningfully resource primary care. Congress and federal agencies should invest in payment and care models that allow primary care clinicians and their teams to coordinate care locally, collaborate with community organizations and public health departments, maximize strengths of specialists, and address social determinants of health—all while reducing long-term costs by improving health outcomes.

How can Congress best address the social determinants of health (SDoH) that influence overall health outcomes in rural, Tribal, and other underserved areas to improve health outcomes in these communities?

Addressing health inequities and SDoH requires a full and accurate view of existing disparities. Primary care physicians are uniquely positioned to help address health related social needs and connecting people to primary care advances equity. Currently, most health data collection efforts at the federal, state, and local level are focused on five broad racial groups, two ethnicities, and variable descriptors for LGBTQ+ people. Without specific indicators, these populations may not receive adequate consideration in budgeting processes and resource allocations, resulting in further disadvantage. We support collecting more detailed data that includes specific ethnic groups within each race based upon broader similarities such as country/continent of origin, language, and religious background, and sexual orientation and gender identity including individuals who are lesbian, gay, bisexual, and/or transgender. These more detailed groups should be standardized for data collection purposes across health care stakeholders. We also urge the Office of the National Coordinator for Health Information Technology to continue its work with electronic health record (EHR) vendors to ensure new standards are incorporated into existing platforms without imposing additional costs on physician practices.

As data collection becomes more specific, it is vital that aggregate data sets protect patients' confidentiality. Additionally, all aggregated data should be easily accessible by physicians and administrators, particularly for those in community-based settings. Aggregate datasets that can be accurately stratified by race and ethnicity, as well as sexual orientation and gender identity, are vital tools for physician practices and health care organizations to identify disparities within their patient panel and work to address them. The same is true for data collection and reporting for public health purposes.

How can Congress work to bolster Americans' confidence in public health institutions? How can the federal government work to reverse both short and long-term declines in vaccination against vaccine preventable diseases?

Primary care physicians are integral members of their communities and see firsthand how pervasive health inequities contribute to poor health outcomes, with COVID-19 being just the latest example. As such, they play an integral role in improving the health of the public by diagnosing and treating their patients, as well as counseling patients and administering vaccines.

Vaccination strategies should leverage trusted primary care physicians to improve access to immunizations in patients' own communities and build vaccine confidence. Before and throughout the pandemic, we have advocated for vaccine strategies that leverage trusted primary care physicians to combat vaccine hesitancy and improve access to vaccinations. Evidence indicates that patients trust and want to hear from their personal physician when making decisions about vaccines and would prefer to receive the COVID-19 vaccine in their physician's office.[9]

Physicians working in CHCs and rural health clinics, who are trusted community members, play an especially powerful role in increasing vaccine confidence and access. About 70% of COVID-19 vaccines administered in community health centers have been given to patients of color.[10] Primary care physicians make up the majority of physicians employed by CHCs, which serve low-income communities. We are pleased that CHCs have played a central role in the federal COVID-19 response. The Academy encourages leveraging CHCs and rural health clinics in other vaccination and public health efforts since they play a key role in mitigating inequities and improving access to vaccines and affordable health care.

We were pleased that Congress recently allocated $1 billion to build vaccine confidence, support vaccine education, and improve vaccination rates for COVID-19 as well as other vaccine preventable diseases. Confidence building activities, inclusive of community leaders, are essential for all vaccines across the life course. We encourage Congress to continue funding these campaigns, including for routine immunizations, and would like to see confidence efforts include all age groups - children, adolescents, and adults.

As a result of the pandemic, routine vaccination rates, across all ages, have plummeted - leaving communities vulnerable to preventable disease, illness, and outbreaks. It is estimated that 37.1 million doses of recommended vaccines were missed between January 2020 and July 2021.[11] We support making all routinely recommended vaccines widely available to Medicare and Medicaid beneficiaries by eliminating barriers that make immunizations unaffordable for beneficiaries. While some vaccines are covered by law under Medicare Part B, other vaccines fall under the Medicare Part D benefit, where they are often subject to cost sharing. Studies have shown that the cost sharing requirements discourage immunization uptake among older people, people with disabilities, and chronically ill populations. We urge Congress to pass the *Helping Adults Protect Immunity Act* (H.R. 2170) and *Protecting Seniors Through Immunization Act* (H.R. 1978), which eliminate cost sharing for all adult routine immunizations in Medicare and Medicaid.

In the Medicare and Medicaid programs, primary care physicians are unable to bill for the time they spend counseling patients on the importance and safety of COVID-19 and routine vaccinations. These conversations can take place over several visits and may not result in a reimbursable vaccination. While the recent increase in Medicare reimbursement for vaccine administration has been helpful for offsetting costs, it is inadequate, particularly for smaller, independent practices. We encourage Congress to work with CMS to ensure physician practices in Medicare and Medicaid can be paid for the vital vaccine counseling services they are providing, including when calling patients and encouraging them to be vaccinated.

What policy considerations should Congress examine concerning improving public health and public health infrastructure?

The COVID-19 pandemic has highlighted the need to bolster investments in our nation's public health infrastructure. Primary care activities, such as clinical preventive services, early diagnosis and intervention, quality-driven and evidence-based care, health promotion, and health advocacy, reinforce public health activities. Likewise, public health activities, such as population surveillance, disease control, health promotion and interventions based on determinants of health, injury prevention, and policy formation facilitate primary care's ability to function within the health care system. We urge Congress to invest in our nation's public health to build workforce capacity, expand laboratory systems and improve health information systems.

Immunizations are essential to protecting individuals across the life course from vaccine-preventable diseases and outbreaks. The ability to exchange immunization information across multiple jurisdictions can improve immunization rates, saving lives and dollars. Immunization Information Systems (IIS) are an essential tool for achieving this, informing providers of the vaccines a patient needs and when they need them. During past pandemics and natural disasters, IIS have been able to respond to the unique and pressing issues that these public health emergencies present for affected communities. However, IIS vary across states in terms of their capabilities and the breadth of patient information contained. Now is the time to streamline policies across states and localities to facilitate the secure and confidential sharing of immunization record data across IIS' jurisdictions on a more permanent basis. This would reduce immunization gaps, empower providers, and integrate immunization data into 21st-century health systems. We urge Congress to pass the *Immunization Infrastructure Modernization Act* (H.R. 550), which would provide much needed resources for IIS modernization, interoperability, and enhancements.

How can Congress better utilize existing programs to address the maternal health crisis?

The U.S. is the only industrialized nation with a maternal mortality rate that is on the rise.[12] According to the Centers for Disease Control and Prevention (CDC), approximately 700 pregnancy-related deaths occur in the U.S. each year, and it is estimated that more than half of these deaths are preventable.[13] Especially concerning are the stark racial inequities in maternal mortality: Black women and Indigenous women are 3.3 and 2.5 times more likely, respectively, to die from pregnancy-related causes than non-Hispanic white women.[14] Further, the COVID-19 pandemic is exacerbating the maternal mortality crisis.[15] According to the CDC, pregnant people are at an increased risk for severe illness and death from COVID-19 when compared to non-pregnant people, and may be more likely to require hospitalization, intensive care, and ventilation.[16]

We urge the Task Force to support passage of the *Maternal Health Quality Improvement Act* (H.R. 4387) to help address the maternal health crisis. The bill ensures states have the evidence-based tools and support needed to implement maternal mortality review committees (MMRC) findings and recommendations. MMRCs are best positioned to comprehensively assess and characterize maternal deaths, to understand the causes and contributing factors and identify opportunities for prevention. H.R. 4387 also improves access to obstetric care in rural areas and addresses racial and ethnic health inequities through bias training and increasing the provision of culturally congruent and respectful care.

Additional Recommendations

Equitable Vaccine & Testing Distribution – Initial federal distribution plans for COVID-19 vaccines have focused heavily on mass vaccination sites, retail pharmacies, and community health centers, with the administration citing logistic challenges with distributing to community-based physician practices. However, more recent efforts to prioritize primary care in vaccination efforts, including as

part of the rollout of pediatric COVID-19 vaccines, has reaffirmed the integral role they play. Data shows that primary care physicians provide most vaccinations in the U.S. and therefore are uniquely well positioned to lead the push for COVID-19 immunization.[17] Most primary care physicians are also providing COVID-19 testing services in their practices. However, the increased demand for COVID-19 testing driven by the omicron variant, vaccine mandates, and students returning to school has resulted in physicians having difficulty keeping up with the demand. Despite efforts to increase production of COVID-19 testing, physician practices are still struggling to keep sufficient inventory. We call on Congress to support federal, state, and local efforts to ensure that community-based primary care practices are included and prioritized in vaccine and testing distribution in the current and future pandemics.

Primary Care Workforce - COVID-19 has both highlighted and exacerbated the physician workforce shortages facing communities throughout the nation. It has demonstrated the urgency of building and financing a robust, well-trained, and accessible primary care system in our country. According to the American Association of Medical Colleges, we will need up to 48,000 additional primary care physicians by 2034 to meet the health care needs of our growing and aging population and be prepared to respond to future crises. Congress should address the primary care physician shortage by increasing investments in the Teaching Health Center Graduate Medical Education (THCGME) program, the Conrad Waiver 30 program, and the National Health Service Corps program, which train and place primary care physicians in underserved and rural communities.

Physician Burnout & Administrative Burden - Even prior to the pandemic, burnout among clinicians was a pervasive public health concern, with some studies showing more than half reporting burnout. Physician burnout during the COVID-19 pandemic has worsened, negatively impacting happiness, relationships, career satisfaction, and patient care. Federal agencies should continuously conduct research and develop evidence-based guidance to inform health systems, employers, and other stakeholders on how they can use institutional policy changes to prevent and mitigate stress and burnout in the health care workforce.

Congress should also look at ways to reduce administrative burden as it is only accelerating physician burnout. On average, up to 25% of a physician's time is spent on administrative duties. This takes away from their ability to deal with critical matters that involve patient care. In addition to being a leading cause of physician burnout, the opportunity cost of the total time spent on administrative burdens is estimated to be about $15.5 billion dollars annually.[18] Administrative burden causes inefficiencies in both time and money in health care while playing a large role in the declining well-being of physicians.

Medicaid Parity **-** Recent data show that Medicaid enrollment has increased by 12 million since the start of the COVID-19 pandemic, and trends suggest that enrollment will continue to increase as a result of pandemic-related job losses.[19] The demand for primary care physicians in the Medicaid program is more acute than ever. Inadequate Medicaid payment threatens access to primary care services in areas hardest hit by COVID-19, and without proper support during this public health emergency and beyond, physician practices could be forced to close. Congress should ensure Medicaid beneficiaries have timely access to primary care by passing the *Kids Access to Primary Care Act* (H.R. 1025) which raises Medicaid payments for primary care clinicians to at least Medicare payment levels and should also raise rates for mental health providers. This will ensure that primary and mental health care clinicians can sustain their practice and have the resources to care for all patients, regardless of coverage source.

Establish a Countercyclical Federal Matching Assistance Percentage (FMAP) – Medicaid is a countercyclical program - enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment and growth in both the low-income population and the number of people losing employer-sponsored insurance. However, the current financing structure has limited

effectiveness as an automatic economic stabilizer. While Medicaid spending can adjust in response to fluctuations in economic activity, the current formula for sharing Medicaid expenditures between states and the federal government does not allow for a rapid increase in federal contributions when state economic conditions decline, nor does it provide a mechanism for additional federal contributions to stimulate growth during a national recession. Therefore, it is critical that the FMAP be altered and tied to economic indicators, so federal aid increases in accordance with state economic downturns. This will ensure that state Medicaid agencies have adequate resources to meet the health needs of some of their most vulnerable residents during times of emergency. Under current law, states must rely on Congress to obtain an FMAP increase.

Special enrollment period (SEP) – According to HHS data, more than 2 million people signed up for health insurance coverage on the federal or state exchanges from mid-February through the end of June during the COVID-19 special enrollment period. The large number of individuals signing up for health coverage during the SEP highlights the importance of coverage and access to quality health care. Despite significant increases in the number of individuals with health insurance over the past decade, nearly 24 million nonelderly adults remain uninsured nationwide. Patients' well-being is a priority; access to health insurance not only facilitates access to care but also allows them the peace of mind associated with being covered. We call on Congress and federal agencies to use SEP during pandemics and PHE to ensure all Americans can have access to quality, affordable health care coverage. Federal agencies should also train consumer-facing insurance "navigators" to conduct outreach and provide virtual and telephonic enrollment support during SEPs to attract and enroll newly eligible people in qualified health plans.

We look forward to working with the Healthy Future Task Force Security Subcommittee to develop policy solutions that invest in the future of primary care, and ultimately improve the health of our entire nation. If you have questions or would like to discuss our feedback in greater detail, please contact Erica Cischke, AAFP's Director of Legislative and Regulatory Affairs, at ecischke@aafp.org.

Sincerely,

American Academy of Family Physicians
American College of Physicians

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