Response from the
American College of Physicians
To the U.S. Senate Committee on Health, Education, Labor and Pensions
On
“Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act”
Or the
“PREVENT Pandemics Act”
February 2, 2022

The American College of Physicians (ACP) is pleased to submit this response and appreciates that Chair Patty Murray and Ranking Member Richard Burr have invited information from the health-care community about what steps should be taken now to prepare the country for future pandemics. We applaud your commitment to pandemic preparedness and ACP appreciates that the Health, Education, Labor and Pensions (HELP) Committee has been holding hearings about this topic since the beginning of the COVID-19 pandemic in 2020. We therefore commend the January 25, 2022, release of the bipartisan discussion draft of the Prepare to Existing Viruses, Emerging New Threats, and Pandemics Act or the PREVENT Pandemics Act. We hope that this important discussion draft will provide a platform to act on bipartisan solutions improving the nation’s capacity to confront the ongoing national public health emergency (PHE) caused by coronavirus disease 2019 (COVID-19) and more effectively contend with future pandemics. We wish to assist in the HELP Committee’s efforts by offering our input and suggestions to certain provisions of the PREVENT Pandemics Act where the College has relevant policy. ACP has already shared some of the policy recommendations below with the HELP Committee in ACP’s response to “Preparing for the Next Pandemic” in June 2020.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

Federal Leadership and Accountability

The PREVENT Pandemic Act (Sec. 101) would establish the 12-member ‘‘National Task Force on the Response of the United States to the COVID–19 Pandemic’’ that would review the United States’ response to the COVID-19 pandemic. That assessment would include initial and ongoing Federal, state, and local responses to COVID-19 in order to identify gaps and make recommendations to both the President and Congress. The Task Force’s membership would be appointed by bipartisan Congressional and Committee leadership and compromised of individuals with expertise in public health, health

disparities, medicine, public health preparedness, commerce, national security, and foreign affairs as well as other related fields.

ACP strongly supports the concept of a congressionally-mandated bipartisan commission to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness. Earlier in the 117th Congress, the ACP supported the National Coronavirus Commission Act of 2021, S. 412, which would establish a ten-member independent body comprised of prominent Americans with expertise in government service, public health, commerce, scientific research, public administration, intelligence gathering, national security, and/or foreign affairs.

With regard to the individuals serving on the Task Force, we strongly believe that it is absolutely essential that the commission include physicians with expertise in pandemic preparedness and response, including primary care physicians who have been on the frontlines of treating patients with COVID-19. Our physicians have the experience, expertise, and knowledge to guide the commission to determine—in a thorough non-partisan manner—the areas in which we can improve our nation's preparedness and response to future pandemics.

State and Local Readiness

The PREVENT Pandemics Act bolsters state and local public health security through ensuring coordination between local health departments and state agencies (Sec. 111) and supports access to mental health and substance use disorder services during public health emergencies (Sec. 112).

ACP recommends that the federal government provide state and local authorities with the resources, funding and effective distribution based on need to 1) ensure sufficient testing capacity, contact tracing and the workforce needed for follow-up, 2) personal protective equipment (PPE), 3) health system treatment capacity. While state and local governments and public health authorities have the principal role in making decisions on mitigating COVID-19 and building up and sustaining health system capacity, the federal government must do all that it can to ensure sufficient funding and resources to allow such decisions to be made and implemented safely and effectively, resourced to high risk communities, and to communities where surges may not yet have occurred but where resources are needed to control the spread of the virus early. ACP has said that the federal government must do more than it has done thus far to ensure that the required tests, workforce capacity, supplies, and PPE are available and distributed based on need.[1]

In April 2021, in ACP's statement to the HELP Committee for the hearing "Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders ", the College provided input and recommendations surrounding COVID-19 and mental health and substance use disorders (SUDs), including integrating primary care and behavioral health, expanding the available tools to treat mental health SUDs, and increasing the physician workforce.

ACP strongly supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources. Accordingly, ACP supports using the primary care setting as the springboard for addressing both

physical and behavioral health care. ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work to remove payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care. The barriers to seamless integration of behavioral and primary care are both administrative and financial. Behavioral and physical health care clinicians have a long history of operating in different care silos. Accordingly, Congress can and should take action to encourage primary care and behavioral health integration. Congress could establish grant programs with adequate funding to incentivize primary care uptake of the various integrated care models. These grants could help defray costs of establishing and delivering integrated primary and behavioral health services. We urge Congress to pass the Collaborate in an Orderly and Cohesive Manner (CoCM) Act, H.R. 5218, that would provide grants through the Department of Health and Human Services to primary care physicians that choose to deliver behavioral health care through the Collaborative Care Model (CoCM). CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads.

One of the barriers to true integrated primary and behavioral health care are the likely instances of noncompliance by insurance plans with mental and SUD coverage parity required by federal law. While the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity for mental health and SUD coverage, state and federal oversight and compliance efforts have been uneven. Unfortunately, according to the GAO, the true nature of the problem of noncompliance with MHPAEA is not well known.[2] ACP strongly recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that remain barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws, including oversight and compliance efforts by federal and state agencies.[3]

ACP reiterates its support for the establishment of a national of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. The College strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. In addition to a national PDMP, ACP strongly encourages Congress to be helpful in this area by requiring efforts to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs.[4]

ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. Cross-discipline training is needed to prepare behavioral health and primary care physicians to effectively integrate their respective specialties. Primary care physicians need to be trained to screen, manage, and treat common behavioral health conditions, and behavioral health providers need to be trained to understand care for common medical needs. Both sectors need to overcome the operational and cultural barriers that prevent seamless integration.

Addressing Disparities and Improving Public Health Emergency Responses

Through establishing grant programs (Sec. 201) to reduce health disparities by increasing capacity to address social drivers and to determine best practices to improve health outcomes by addressing social drivers the PREVENT Pandemics Act attempts to address health disparities during a PHE.

In March 2021, in ACP's statement to the HELP Committee for the hearing "Examining Our COVID-19 Response: Improving Health Equity and Outcomes by Addressing Health Disparities", the College provided input and recommendations surrounding COVID-19 and health disparities during the pandemic. In April 2020, early on in the pandemic, ACP strongly urged that the U.S. Department of Health and Human Services (HHS) and other federal agencies collect and publicly release racial, ethnic, and patients' preferred language data regarding COVID-19 testing, hospitalizations, and deaths. This need remains imperative to equip physicians, researchers, and policymakers with sufficient information to better understand the circumstances and characteristics unique to treating and caring for racial and ethnic minority communities and those with limited English proficiency (LEP). At the beginning of 2021, ACP released the position paper, "Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk," which offered specific recommendations to address issues that disproportionately impact racial and ethnic minorities, including during a pandemic.

ACP believes that policymakers should recognize and address how increases in the frequency and severity of public health crises, including large-scale infectious disease outbreaks such as COVID-19, poor environmental health, and climate change, all disproportionately contribute to health disparities for Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other vulnerable persons.[5]

Specifically, there are actions that Congress should take or require that the administration take, either immediately or in the short term, to mitigate the impact of COVID and future pandemics across racial and ethnic minority populations:

- **Collect COVID-19 and Racial Disparity Data.** Collect racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic and release that data in a uniform and timely manner at a local and national level. These data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care.[6]

- **Equitably Distribute COVID-19 Vaccines and Treatments.** Testing, treatments, vaccines, and other resources should be equitably distributed in a transparent manner based on need, especially in historically underserved racial and ethnic minority neighborhoods. These services and supplies should be affordable and accessible regardless of socioeconomic status.[7]

- **Protect Essential Workers.** With so many members of racial and ethnic minority populations required to work during the PHE caused by COVID-19, the U.S. Department of Labor's (DOL)

Occupational Safety and Health Administration (OSHA) should issue appropriate workplace protections to protect the health and well-being of essential workers during a pandemic.[8]

- **Permanently Expand Access to Family and Medical Leave.** Congress should provide universal access to family and medical leave that provides a minimum period of six weeks of paid leave that should be mandated and funded, with flexibility that allows for the caring of family members, as recommended in "Women's Health Policy in the United States".[9] Legislative or regulatory action at the federal, state, or local level are needed to advance this goal.[10]

- **Address Environmental and Social Drivers of Health.** Environmental factors and other social drivers of health that disproportionately affect racial and ethnic minorities, including the impact on health of large-scale infectious disease outbreaks and climate change, must be addressed as recommended in "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health",[11] "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" ,[12] and "Climate Change and Health".[13] [14] These social drivers and environmental factors influence an individual's health status even though they are sometimes not part of the health care system. It is likely that existing comorbidities do not fully explain COVID-19 disparities and that other factors like structural racism, uninsurance, poor quality of care, food and housing insecurity, workplace risks, and other social drivers of health have contributed to these disparities.[15] These issues can include the location of an individual's neighborhood and community, environmental conditions—such as pollution and air quality—of where someone lives, access to quality housing, access to good transportation resources, meaningful employment opportunities, and negative interactions with the criminal justice system.[16]

<u>Improving Public Health Data</u>

As the pandemic has revealed, improving public health data is necessary to give policymakers and clinicians the tools to effectively respond to PHEs. The PREVENT Pandemics Act would modernize biosurveillance and infectious disease data collection (Sec. 211) and support public health data availability and access (Sec. 213). ACP supports the federal government ensuring sufficient funding and coordination for public health data surveillance and analytics infrastructure modernization. Improving the public health surveillance and analytics infrastructure is important in addressing the next phase of the current COVID-19 pandemic, as well as improving the ability of public health departments to address future public health emergencies. ACP remains concerned that physicians' existing health information technology (IT) systems lack the ability to seamlessly report COVID-19 cases and public health departments vary in their ability to accept these reports. The goal for improving these processes should focus on automating data sharing from health IT systems with minimal additional effort required by clinicians, and implementing these programs through a coordinated effort focused on agreed upon standards that are implemented consistently across vendors and states. Further, Congress should take into account and incorporate necessary privacy guardrails as these surveillance and analytics systems are improved and expanded.

ACP recommends that any uses of technology in the U.S. in the context of pandemic should be demonstrated to be effective, be temporary, and ensure safeguards for privacy and confidentiality are

in place. ACP recommends that physicians and their care teams and patients should be actively involved in the development, testing, and implementation of any public health surveillance technology or application.

- Public health surveillance technologies or applications should be made equally available to everyone interested in using them in a non-discriminatory manner.
- There should be clear mechanisms in place regarding the governance and oversight of public health surveillance technologies and applications and developers should use open source coding approaches in order to allow for independent and regulatory audit.[17] [18]
- The broader contact tracing workforce needs to be provided education and training regarding the ethics of public health data collection and use, how to properly manage public health data, risk communication, cultural sensitivity, and the specifics of local processes and data collection efforts.[19]
- Data collection and analysis infrastructures that are used in testing and surveillance should both prioritize connection to needed care for the individual user and provide support for COVID-19 decision making at the population-level to the extent possible, in order to help mitigate and ideally reduce disease spread.[20]
- All such technologies should first be tested in demonstration projects to the extent feasible due to the time-sensitive nature of this pandemic to assess the effectiveness and unforeseen consequences.[21] If implemented, they should constantly be monitored to determine their impact on disease mitigation, ideally based on predetermined measures that are developed with input from physicians and their care teams and patients.[22]
- Information on this impact should be shared publicly,[23] and mechanisms should proactively be put in place to shut down the use of a technology or app if it is deemed ineffective, unethical in its implementation, or no longer needed.[24]

ACP recommends that extensive safeguards must proactively be put into place in order to ensure user privacy and responsible data management by any public health surveillance technologies or applications.[25]

Revitalizing the Public Health Workforce

The PREVENT Pandemics Act contains several provisions that ACP would support that reauthorizes the Public Health Workforce Loan Repayment Program (Sec. 221), recruits and trains community health workers (Sec. 222), and improves public health emergency response (Sec. 223). However, Congress must go further in ensuring adequate enough numbers of clinicians to respond to the ongoing COVID pandemic and future PHEs. In May 2021, in ACP's statement to the Subcommittee on Primary Health and Retirement Security of the HELP Committee for the hearing, "A Dire Shortage and Getting Worse: Solving the Crisis in the Health Care Workforce", that immediate action was necessary to address the existing and growing physician workforce shortage through expansion of federal programs such as Medicare supported graduate medical education (GME), the National Health Service Corps (NHSC), and the Public Service Loan Forgiveness (PSLF) program, in addition to other programs and legislation outlined below that Congress can enact now.

The COVID-19 global pandemic continues to take a toll on virtually all aspects of the U.S. economy and health care system including on physicians. Internal medicine specialists in particular have been and

continue to be on the frontlines of patient care during the pandemic. Many physicians were asked to come out of retirement to provide care, and there continues to be an increasing reliance on medical graduates, both U.S. and international, to serve on the frontlines in this fight against COVID-19 and deliver primary care.

ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide primary care to patients. Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.[26]

ACP supports several pieces of legislation introduced that should be passed in the current 117th Congress to assist medical graduates and the overall physician workforce as well as address the mental and behavioral health needs of physicians themselves.

- The Resident Education Deferred Interest Act (H.R. 4122) would make it possible for residents to defer interest on their loans.
- The Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 948, 117th Congress) and the Healthcare Workforce Resilience Act (H.R. 2255, S. 1024), would help with medical student loan forgiveness and support IMGs and their families by temporarily easing immigration-related restrictions so IMGs and other critical health care workers can enter the U.S. to train in internal medicine residency programs, assist in the fight against COVID-19, and provide a pathway to permanent residency status.
- The Student Loan Forgiveness for Frontline Health Workers Act (H.R. 2418) would assist frontline clinicians as they provide care during the pandemic.

ACP is greatly concerned by the already high and ever-increasing cost of obtaining a medical education and the impact those expenses have on the number of medical students and residents opting to enter careers in primary care. The Public Service Loan Forgiveness (PSLF) program was established with the goal of boosting the number of individuals choosing a career pathway in public service or a specific or high-need profession that promotes the overall public good. Borrowers of federal student loans, such as Direct Subsidized Loans and Direct Unsubsidized Loans, including Direct PLUS loans for graduate students, are eligible for the PSLF program across a range of professions, including medicine. Unfortunately, several issues emerged, especially in the initial years of PSLF program availability that started in 2007, which made the PSLF program difficult to access. These issues resulted in a high percentage of PSLF applications being outright denied and an astonishingly low number of applicants actually getting their loans forgiven after the required 120 payments (usually 10 years) beginning in 2017. There have been reports of servicers failing to place borrowers in the right service plans, qualifying payments being miscounted, employment certification being improperly disqualified, misinformation by loan servicers, and a general lack of education and awareness by applicants due to inadequate outreach and guidance. ACP feels strongly that the federal government should create incentives for medical students to pursue careers in primary care and practice in areas of the nation

with greatest need by developing or expanding programs that eliminate student debt for these individuals—linked to a reasonable service obligation in the field and creating incentives for these physicians to remain in underserved areas after completing their service obligation. Therefore, ACP was pleased by several changes to the PSLF program made by the What You Can Do For Your Country Act, (H.R. 2441/S. 1203, 116th Congress), introduced in the previous 116th Congress that would hopefully help extend the program to future physicians and encourage them to choose career paths in public service and nonprofits that help serve the overall public health, especially in primary care and underserved areas. The bill would make all types of federal student loans qualify for the PSLF program, including Federal Family Education Loan (FFEL) loans that were previously left out—and permit consolidation to a Direct Loan without losing previously made payments counting towards the overall required PSLF payments. Confusion about which repayment plans were eligible for the PSLF program led to the denial of PSLF applications. Accordingly, the legislation would also permit all federal repayment plans to qualify for the PSLF program. The Act would also enable borrowers to receive loan forgiveness at a 50 percent level after five years of the required payments instead of waiting for full forgiveness after 10 years of payments. The measure would attempt to remedy the education and awareness deficit surrounding the PSLF program by improving resources with accurate information, helping applicants determine whether they qualify for the PSLF program, making it possible for borrowers to check on their payment status, and being able to effectively dispute payment issues. ACP calls on Congress to reintroduce and pass the What You Can Do For Your Country Act in the 117th Congress.

ACP was encouraged that bipartisan congressional leaders worked together in 2020 to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the Consolidated Appropriations Act, 2021 (H.R. 133)—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs). The training and costs associated with becoming a medical or osteopathic doctor (M.D. or D.O) are significant. A student who chooses medicine as a career can expect to spend four years in medical school, followed by three to nine years of graduate medical education (GME), depending on the choice of specialty. GME is the process by which graduated medical students progress to become competent practitioners in a particular field of medicine. These programs, referred to as residencies and fellowships, allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation's workforce needs, as GME is the ultimate determinant of the output of physicians. With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over $15 billion annually), with most of the support coming from Medicare. ACP now calls on Congress to pass the Resident Physician Reduction Shortage Act of 2021 (H.R. 2256/S. 834) which would provide 14,000 new GME positions over seven years, or 2,000 per year to build on the 1,000 new GME slots mentioned above.

ACP also supports other physician and clinician workforce programs and we strongly supported providing $800 million for the National Health Service Corps (NHSC) and $330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were enacted in the American Rescue Plan (ARP) Act, H.R.

1319. Congress needs to continue the increased funding for the National Health Service Corps (NHSC) and Teaching Health Centers Graduate Medical Education (THCGME). Indeed, a study appearing in the Annals of Internal Medicine showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy. Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care. Enhanced investments in programs such as the NHSC and THCGME that increase the physician workforce should be sustained after the pandemic caused by COVID-19 has come to an end.

Another federally-funded program, the Title VII Health Professions, is also instrumental in training physicians in primary care, specifically in the fields of general internal medicine, general pediatrics, and family medicine. While the College appreciates the $10 million increase to the Primary Care and Training Enhancement (PCTE) program in FY2018, ACP urges more funding because the PCTE program is the only program of its kind. Therefore, PCTE funding is critical to the future pipeline of primary care physicians in the workforce. The Title VII Health Professions Training in Primary Care and Training Enhancement (PCTE) received $48.92 million in in federal funding for FY2021. General internists, who have long been at the frontline of patient care, have benefitted from the program's training models emphasizing interdisciplinary training or from primary care training specifically in rural and underserved areas that have helped prepare them for a career in primary care.

Modernizing and Strengthening the Supply Chain for Vital Medical Products

The PREVENT Pandemics Act has several provisions to bolster the Strategic National Stockpile (SNS) including assessing SNS supply chain issues for the (Sec. 402), adequately maintaining equipment in the SNS (Sec. 403), providing transparency for states about accessing the SNS (Sec. 404), improving supply-chain flexibility of the SNS (Sec. 405), and regular monitoring of SNS depletion (Sec 408).

ACP believes that the federal government should use all possible means to ensure that there is sufficient funding, manufacturing, supply, and distribution capacity to get Personal Protective Equipment (PPE) immediately to every physician, nurse, and health worker not only on the front lines of caring for patients who may be infected due to a pandemic, but as well as those individuals caring for patients in general. The Strategic National Stockpile (SNS) needs to procure sufficient enough pharmaceuticals, personal protective equipment (PPE), and other medical supplies, which can be distributed to State and local health agencies in areas with shortages during a pandemic. However, the grim reality was that frontline health care workers were not able to get the PPE they needed to protect themselves and their patients during the COVID-19 pandemic and some shortages remain ongoing. Nothing can be more urgent than rapidly increasing the supply and distribution of PPE during the opening days of a pandemic.

In addition, the use of the Defense Production Act to require the manufacture of PPE should be invoked early on during a pandemic to protect physicians, nurses, and other frontline health care workers. As we saw during the current PHE, such action was sorely needed to address the COVID-19-induced shortage of masks, gowns, gloves, and other PPE that put frontline medical professionals who

were caring for patients at grave risk of becoming infected and sickened by the virus, and then spreading it to colleagues, family members, and patients.

ACP also supports measures to increase pandemic influenza vaccine and antiviral medications in the SNS. ACP supports the national procurement of vaccine in an amount sufficient to protect the entire U.S. population and national procurement of antiviral medications to cover 25% of the U.S. population. ACP believes that additional courses of antiviral medications should be safeguarded in the Strategic National Stockpile for all public safety officers and health care workers with direct patient contact in amounts sufficient to provide prophylaxis. In the event of pandemic influenza, stockpiled vaccine and antivirals should be distributed equitably to all states' public health authorities based on the numbers of people in high-risk and high-priority groups.[27]

Conclusion

We commend you for working in a bipartisan fashion to develop the discussion draft of the PREVENT Pandemics Act to combat the ongoing Coronavirus crisis—as well as future pandemics—through consideration of policies that can be enacted during the 117th Congress. We wish to assist the HELP Committee's efforts in this area by offering our input and suggestions about ways that Congress and federal health departments and agencies can intervene through evidence-based policies to continue preparedness for the next pandemic. Thank you for consideration of our recommendations that are offered the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior Associate, Legislative Affairs, by phone at (202) 261-4526 or via email at jfrost@acponline.org with any further questions or if you need additional information.

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