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April 17, 2020

The Honorable Michael Pence
Vice President
United States of America
Old Executive Office Building
Washington, DC 20501

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
H-232, United States Capitol
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
United States Senate
S-226, United States Capitol
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
H-204, United States Capitol
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
United States Senate
S-255, United States Capitol
Washington, DC 20510

Dear Vice President Pence, Speaker Pelosi, House Minority Leader McCarthy, Senate Majority Leader McConnell, and Senate Minority Leader Schumer:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for your continued efforts to combat the Coronavirus Disease 2019 (COVID-19) outbreak caused by the SARS-CoV-2 virus. As you know, our member teaching hospitals and physicians continue to respond from the front lines of this pandemic, and their efforts are a needed cornerstone in mitigating this crisis.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC member teaching hospitals are critical institutions for delivering patient care, providing 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and are home to 69% of all Level 1 Trauma Centers. Our members are well-established and respected regional referral centers and centers for tertiary care.

They have years of experience in mobilizing resources during times of crisis, and often lead regional responses in collaboration with their state and local departments of health, regional emergency management systems, and all other major players in emergency response. States and localities look to our members for launching initial responses and to aid the development of regional response networks.

Major teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19. Our members continue to provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. Our emergency rooms are open to anyone in need, with experts in medical specialties available 24/7. As we have heard from our members and seen on national news reports, COVID-19 patients tend to be sicker and require prolonged hospitalizations, including being placed on ventilators in intensive care units (ICUs). Teaching hospitals will treat most of these complex patients and, for many, the cost of care will greatly exceed the reimbursement hospitals receive.

Major teaching hospitals consistently maintain a heightened level of preparedness to engage rapidly in response to any event at any time. This unique proficiency helped to lead the nation's response to past public health emergencies and disease outbreaks such as measles, Ebola, and H1N1, and now is a key asset in combatting COVID-19. And even amid this crisis, teaching hospitals currently battling a surge in infections and managing the needs of their communities are sharing their knowledge with others.

In addition to patient care, AAMC member institutions are major centers of cutting-edge medical research, with scientists and clinicians at medical schools and teaching hospitals conducting over 50% of extramural research funded by the National Institutes of Health (NIH). Many of our member institutions have developed much-needed tests for COVID-19, a fluid and rapidly changing area as they bring new equipment online, try to source materials, and stand up reporting procedures in battlefield-like conditions. They are also at the forefront of research efforts to identify and advance clinical care protocols, viable therapeutics and innovative vaccines to blunt the pandemic's impact.

The AAMC appreciates the rapid passage and enactment of three COVID-19 supplemental spending bills, including the most recently passed "Coronavirus Aid, Relief, and Economic Security Act" (CARES Act, P.L. 116-136). Among other important provisions, we are grateful the CARES Act took a crucial step toward ensuring that health care providers get essential support through the establishment of the new Provider Relief Fund. Passage of these bills has been critical in supporting the nation's response to COVID-19 to date.

At the same time, AAMC members on the front lines are continuing to see and experience first-hand the challenges that patients, the health care system, and the nation continue to face. As we enter a new phase in the pandemic, the AAMC urges additional legislation and regulatory relief to equip major teaching hospitals and medical schools across the country, along with other providers, researchers and public health professionals, with the resources and authorities they need to sustain a vigorous response in the near term and to lay the necessary groundwork to

prevent or respond to the pandemic's recurrence. As we indicated in the letter the AAMC sent on April 9, we hope Congress takes immediate action on providing additional resources for the Provider Relief Fund and support for the nation's research enterprise, as part of the interim funding package currently under consideration. As you consider additional comprehensive legislation to support the nation's response and recovery efforts, below we provide further recommendations spanning the multiple mission areas of academic medicine: patient care, medical research, testing and public health, and education.

Our recommendations to address COVID-19's impacts include:

Patient Care

- Ensure hospitals and faculty physicians have financial resources to continue providing quality care to COVID-19 and all patients
- Establish a provider loan program
- Temporarily increase the Medicare indirect medical education (IME) payment add-on adjustment
- Clarify CMS policy to ensure that hospitals that temporarily increase inpatient beds do not impact Intern and Resident to Bed (IRB) ratio calculations which would unfairly reduce teaching hospital payments
- Eliminate scheduled Medicaid Disproportionate Share Hospital (DSH) cuts and provide a Medicaid DSH add-on during the COVID-19 emergency
- Provide an additional increase in the Medicaid Federal Medical Assistance Percentage (FMAP)
- Ensure health care coverage for vulnerable populations by using federal levers to expand health care coverage access and prevent the finalization of the Medicaid Fiscal Accountability Regulation (MFAR)
- Expand the physician workforce to meet this and future health care challenges
- Provide a temporary national license for physicians and other health care workers to allow them to practice across state lines for the duration of the public health emergency
- Provide hazard pay for health care workers
- Provide a technical fix for the accelerated loan program including a more lenient repayment timeline and a more reasonable interest rate
- Protect providers responding to the COVID-19 crisis by expanding "Good Samaritan" protections
- Avoid implementing potentially harmful policies in this time of crisis, such as requiring standards that could inadvertently encourage the rapid depletion of already scarce personal protective equipment (PPE) resources

Medical Research

- Provide emergency supplemental funding to mitigate COVID-19-related disruptions to federally funded research
- Allow period of disbursement extensions for RF1, UF1, and other multi-year grants to ensure awardees do not lose current funding or that their grant deadlines expire while labs are closed

Testing and Public Health

- Invest in public health infrastructure
- Support the academic medicine community's efforts to maximize testing capacity
- Enhance national COVID-19 data collection to better address health disparities

Medical and Graduate Education

- Maintain the US health and research workforce by extending visas, streamlining approval of new visas and changes of status, providing flexibility to sponsors in deploying visa holders where they are needed, expanding Conrad 30, and maintaining work authorization for Deferred Action for Childhood Arrivals (DACA) recipients
- Invest in health professions students and provide tax relief to students, medical schools, and hospitals

Additional details on these recommendations follow.

Patient Care

Ensure hospitals and faculty physicians have resources to continue providing quality care to COVID-19 and all patients

We are grateful for the resources Congress invested through the CARES Act in the new Provider Relief Fund, which will begin to address the enormous challenges and tremendous financial stress the COVID-19 pandemic has placed on the health care system. The unprecedented scope and exponential growth of this pandemic, however, already demonstrates that the Provider Relief Fund's current allocation will be insufficient to adequately support the current and future needs of hospitals and physicians, not to mention all other engaged providers.

AAMC member teaching hospitals and faculty physicians have risen to the call to continue to provide exceptional patient care in harrowing conditions. Our data analysis of fiscal year (FY) 2018 data shows that teaching hospitals, while roughly one-third of all Medicare Inpatient Prospective Payment System (IPPS) hospitals, treat 61% of all cases requiring long-term ventilatory support and/or peripheral extracorporeal membrane oxygenation (ECMO) (Medicare Severity-Diagnosis Related Group [MS-DRG] 207). Moreover, these hospitals treat 59% of all patients requiring short-term ventilator support (MS-DRG 208).[1] Given this experience, teaching hospitals are likely to be the site of care for the most complex and challenging COVID-19 patients, which we are already seeing and hearing from media reports and our members. In addition, our teaching hospitals are noting that the length of stay for COVID-19 patients is significantly longer than for other patients, including longer ICU stays.

While we appreciate the increase in the MS-DRG relative weights included in the CARES Act, we are concerned that it will not cover the unique costs associated with treating COVID-19 patients. Additionally, care for patients suspected of COVID-19 who ultimately test negative is just as complex and intense. It's important that these cases receive the payment increase as well.

[1] AAMC Analysis of Medicare hospital inpatient claims from the FY2018 Medicare Provider Analysis and Review (MedPAR) database.

Academic medical centers and physician faculty practices are strained for supplies as they continue to deploy personnel and resources in the face of this crisis – all while cancelling non-essential "elective" surgeries, procedures, and routine appointments, and redeploying staff to perform other duties as needed. At many institutions, these scheduled, non-urgent services make up a substantial proportion of daily operations. Our members report that hospital occupancy rates have dropped by as much as 30%, and in some cases even more, as they prepare for surges in COVID-19 cases. As a result, their costs are mounting as they respond to the pandemic, but reimbursement is down markedly. It is estimated that some teaching hospitals and health systems are losing between $2 million and $8 million per day. As our member hospitals already operate at capacity during normal situations, it will be impossible for them to recover this lost revenue once the crisis has subsided.

Faculty physician practices are also taking steep financial hits as focus has shifted to crisis response. These practices, which are affiliated with teaching hospitals and health systems, have contributed to the broader system preparation for surge capacity, including redeployment of staff and resources to the COVID-19 front line. The pandemic is causing further significant disruption to these types of physician practices due to the cancellation of elective procedures and other nonurgent patient care visits and the fact that most payers, including Medicare, pay physicians based on the number of in-person visits and procedures they provide. While some services (e.g., evaluation and management services) can be provided by telehealth, procedure-based services cannot, yet physician practices still must maintain the payment of their expenses, including costs associated with facilities, payroll, malpractice liability, and others. Because faculty practices, on average, employ 989 physicians in addition to other staff, most will not qualify for the small business relief established in the CARES Act, and it will be impossible for these practices to make up for their lost revenue.

The CARES Act explicitly establishes the Provider Relief Fund to assist providers in recovering revenue losses and other expenses attributable to their COVID-19 efforts, and both teaching hospitals and faculty physician practices are expected to lose significant revenue during the pandemic that most likely cannot be recovered. Providers that are already operating at or near negative margins will be unable to fill the revenue gap that is exacerbated as a result of preparing to and responding to this crisis and will also struggle to continue normal or heightened operations.

Given the overwhelming demand for support from the Provider Relief Fund – both within and beyond academic medicine alone – we believe that the immense scope and magnitude of this emergency warrants substantial additional investment in the Provider Relief Fund to adequately support the current and future needs of all health care providers, including teaching hospitals and physicians. We urge you to increase resources in the Provider Relief Fund to ensure appropriate support for the academic medical centers that are fundamental to the nation's response, in addition to other providers in need. Additionally, as HHS continues distribution of the Provider Relief Fund, we strongly support direct and efficient payments to the frontline providers who are currently treating patients and those that have enhanced capabilities, experience, and have taken steps to mount a response to COVID-19.

Establish a provider loan program

While we greatly appreciate the Provider Relief Fund and strongly support increasing its size, teaching hospitals and faculty practice plans remain concerned about their ability to access adequate resources and capital. Even with allocations from the Provider Relief Fund, it is likely that providers will not be made whole. Another challenge facing many teaching hospitals and faculty practice plans is that they will not qualify for the Small Business Administration loan programs included in the CARES Act. Congress also created the Main Street Lending Program for businesses between 500-10,000 employees. This program includes lower interest rates but does not offer the same benefits afforded to smaller physician practices. Specifically, it does not provide the same opportunity for loan forgiveness as the small business loan program. For this reason, the AAMC supports the creation of a targeted provider loan program that would offer health care providers access to low-interest loans. These loans could be an additional mechanism to help providers offset revenue shortfalls and support additional expenses.

Temporarily increase Medicare indirect medical education (IME) payment add-on adjustment

Major teaching hospitals are the point of care for the most complex and challenging patients with the greatest care needs, and that is particularly true at a time like this when communities and the nation are relying on teaching hospitals for widespread diagnosis and treatment of COVID-19 patients. Medicare IME payments were created in large part to address the additional costs teaching hospitals incur for being these front-line providers for specialized care in normal times and unique care and surge capacity in times of national emergency. As facilities that are experienced in administering research protocols, major teaching hospitals are adept at deploying care innovations and managing cases that are not well understood. The novel nature of COVID-19 dictates that communities will rely on major teaching hospitals to be on the front lines of the pandemic, above and beyond what current payments support, and they will still be tasked with caring for the most complex cases. A temporary increase in Medicare IME payments is essential to provide critical support for these front-line providers.

Clarify Centers for Medicare and Medicaid Services (CMS) policy to ensure that hospitals that temporarily increase inpatient beds do not impact Intern and Resident to Bed (IRB) ratio calculations which would unfairly reduce teaching hospital payments

The AAMC is concerned that as teaching hospitals respond to patient surges by adding temporary inpatient beds and utilizing non-traditional patient care areas, they stand to inadvertently and negatively affect their IRB ratio used to calculate the IME adjustment. Since the IRB is the calculation of the ratio of the number of beds in a hospital and the number of residents/interns training in the hospital, a significant increase in the number of beds stands to significantly lower the IRB ratio, thus reducing the overall IME payment. As these beds are not permanent, and will no longer exist after the emergency subsides, the AAMC believes that, at a minimum, hospitals should be held harmless from facing inappropriate and unfair IME reductions as a result of their rapid response to the COVID-19 pandemic.

We ask that CMS confirm – through interim regulatory guidance or an 1135 waiver – that the addition of temporary hospital beds to respond to COVID-19 will not negatively impact a teaching hospital's IME payments. Or alternatively, that Congress specify this in statute.

Eliminate scheduled Medicaid Disproportionate Share Hospital (DSH) cuts and provide a Medicaid DSH add-on during the COVID-19 emergency

Hospitals are facing substantial cuts through scheduled reductions to Medicaid DSH payments. Though the CARES Act eliminated a portion of the scheduled DSH cuts and delayed others until Dec. 1, 2020, the financial ramifications of treating COVID-19 patients will continue to be felt far beyond that deadline. The AAMC believes that DSH cuts should not only be eliminated, but that Congress should also consider a 2.5% add-on to DSH payments for the period of the COVID-19 emergency. A DSH add-on stands to provide a needed funding boost to teaching hospitals caring for the most vulnerable Medicaid patients, as well as dual eligible beneficiaries under Medicare and Medicaid.

Provide an additional increase in the Federal Medical Assistance Percentage (FMAP)

The second supplemental legislation, the Families First Coronavirus Response Act (P.L. 116-127), provided an additional FMAP increase of 6.2 percentage points – a needed increase to ensure states are able to maintain their Medicaid programs. Building upon the FMAP increase and requiring that states spend the FMAP increase on patient care and provider reimbursement is a critical tool in ensuring that safety-net providers have the necessary resources to care for Medicaid patients, and we encourage Congress to provide a further increased FMAP beyond the 6.2 percentage points authorized in P.L. 116-127.

Ensure health care coverage for vulnerable populations by using federal levers to expand health care coverage access and prevent the finalization of the Medicaid Fiscal Accountability Regulation (MFAR)

To deliver timely and equitable care to all patients who contract COVID-19 and to reduce the public's exposure, it will be essential to ensure that the costs associated with coronavirus care do not deter any patients from seeking care in a timely manner. As safety-net providers, AAMC member institutions care for a disproportionate number of vulnerable patients, including the uninsured and the under-insured. Rather than re-allocating the Provider Relief Fund, we urge the administration to use tools already at its disposal to ensure that every single individual has access to affordable and comprehensive coverage - such as immediately opening up a special enrollment period for the Affordable Care Act's marketplaces and subsidizing Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for people who have lost their job as part of the COVID-19 crisis, as the government has done in the past. For example, the federal government has partially subsidized COBRA benefits for some workers during times of economic uncertainty through the use of "Health Coverage Tax Credits." Congress could once again utilize the tax credits to lessen the burden of purchasing COBRA.

Additionally, the proposed MFAR would cause uncertainty in the Medicaid program and potentially reduce the number of Medicaid enrollees, resulting in more uninsured patients and higher uncompensated care costs. The Medicaid program is a critical lifeline during public health

crises, ensuring that the most vulnerable Americans can access the care that they need. At this time, we should be focused on strengthening the health care safety-net, not dismantling it. Therefore, we ask that MFAR be withdrawn from further consideration.

Expand the physician workforce to meet this and future health care challenges

As we look to the future, now is the time to address the physician shortage and ease outdated restrictions on Medicare support for physician training. In 1997, Congress effectively froze Medicare graduate medical education (GME) funding until physician needs in the U.S. could be re-evaluated. The U.S. is expected to experience a shortage of between 46,900 and 121,900 physicians by 2032 in both primary and specialty care. We believe that the increasing physician shortage over the last two decades has demonstrated that we need to increase the number of physicians. This shortage is being felt acutely as we mobilize on the front lines to combat COVID-19. In fact, data have shown that the U.S. has fewer practicing physicians per 1,000 people than nearly all comparable countries.[2] It is clear that an investment is needed now in order to ensure an appropriate physician workforce that is able to accommodate a growing and aging population, as well as mitigate future crises.

The Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) would take a step toward addressing the physician shortage by gradually and responsibly increasing Medicare's cap on GME by 15,000 slots over five years. We estimate that this will produce an estimated 3,750 new physicians annually when fully implemented. The additional primary care and specialist physicians trained by lifting the cap on Medicare-supported GME will allow the U.S. to more robustly respond to the needs of patients across the country both in the near term and into the future.

Provide a temporary national license for physicians and other health care workers to allow them to practice across state lines for the duration of the public health emergency

Congress and the administration have taken substantial steps to ease regulatory burdens around telehealth practice and payment, but one large barrier remains to fully realizing the capabilities of telehealth – interstate licensure. Additionally, physicians and other providers from across the country have mobilized to help serve communities currently under siege by COVID-19. Numerous physicians have temporarily relocated to another area experiencing heavy COVID-19 cases to lend a hand to the already taxed physician workforce of that location. However, many physicians are unable to heed this call for assistance because they are not licensed in the state where they are needed. Many governors have taken emergency steps to improve access across state lines, but each state has taken different approaches, creating a maze for health care providers to understand the local requirements.

Traditionally an area of regulation left to the states, physicians are unable to treat patients across state lines unless they are licensed in the patient's state or their state has a contract with the other state. The AAMC urges Congress to legislate a temporary uniform licensing standard for all

[2] Kaiser Family Foundation: https://www.healthsystemtracker.org/chart-collection/how-prepared-is-the-us-to-respond-to-covid-19-relative-to-other-countries/

practitioners or professionals in good standing (treating both physical and mental health conditions) in all states for telehealth and in-person visits for the duration of the national emergency as well as a taper period as conditions normalize.

Teaching hospitals and physicians have increased their telemedicine capabilities at an astonishing rate – with some accelerating their telehealth implementation timelines by many years in a matter of weeks. Telemedicine has proven an invaluable resource for teaching hospitals and faculty physicians throughout the crisis, allowing them to continue to see patients without risking infection spread by coming into contact with them, and by also allowing them to screen patients before they present at a hospital for COVID-19 testing. Congress and the administration should build upon these efforts and work with providers to encourage or incentivize Employee Retirement Income Security Act (ERISA) group health plans to provide coverage for the same telehealth and phone services covered by Medicare during the COVID-19 pandemic.

Provide hazard pay for health care workers

The AAMC supports and encourages Congressional consideration of providing hazard pay through the Department of Labor for workers whose jobs are critical in keeping essential health care operations, businesses, and services in place throughout the public health emergency. We urge you to include doctors, resident physicians, nurses, other health professionals, and support staff that are treating patients and assisting care givers on the front lines of this crisis. One such proposal, the COVID-19 "Heroes Fund," would provide payments to recruit, retain, and reward essential frontline providers to combat the pandemic.

Provide a technical fix for the accelerated loan program including a more lenient repayment timeline and a more reasonable interest rate

The AAMC is appreciative that Congress authorized accelerated payments under the Medicare program. However, there is a 10.25% interest rate on loans that are not paid within 12 months for hospitals and 210 days for physicians. This is a harsh penalty that is untenable for providers who are already struggling financially in the midst of the COVID-19 emergency. The AAMC asks that Congress give CMS the authority to issue multiple accelerated payments, delay repayment for two-years post-COVID-19 emergency period, and either forgive the interest or reduce the interest rate to no more than 2%. In addition, we request that Congress reduce the per-claim recoupment amount from 100% to 25%.

Protect providers responding to the COVID-19 crisis by expanding "Good Samaritan" protections

As teaching hospitals, physicians, and other providers take extraordinary steps to respond to the COVID-19 crisis, it is important to recognize that some providers may be thrust into new roles outside of their traditional scope of practice with limited resources or access to necessary tests or equipment. In addition, providers are being asked to postpone elective surgeries and other care which could ultimately lead to the possibility of missed diagnoses or delayed treatment. In these uncertain times, the AAMC urges Congress to build upon the "Good Samaritan" provisions included in the CARES Act (Sec. 3215) and extend those liability protections to all providers who provide medical services during the public health emergency.

Avoid implementing potentially harmful policies in this time of crisis, such as requiring standards that could inadvertently encourage the rapid depletion of already scarce PPE resources

Health care worker safety is a top priority for our institutions – after all, we cannot care for patients if our personnel are also ill. However, the AAMC urges you to consider the practical implications of requiring additional federal agencies to impose strict emergency temporary standards (ETS), particularly when the Centers for Disease Control and Prevention (CDC) is continually refining and updating its guidance for health professionals as the crisis and our understanding of it evolve. There is much we do not know about COVID-19, and as the science reveals more about the virus, standards may change. Legislative proposals that would impose an unnecessary and burdensome standard on hospitals could further deplete already low supplies of PPE without corresponding evidence to demonstrate enhanced safety.

The AAMC urges you to ensure that any proposed policies to protect patients and health care workers do not unintentionally hamper the COVID-19 response or ultimately negatively impact providers and patients in the process. Thus, the AAMC urges that Congress to continue supporting CDC's efforts to update guidance on health care worker protection and avoid requiring other agencies to set an ETS that could inadvertently encourage the rapid repletion of already scarce PPE resources without improving safety.

Medical Research

Provide emergency supplemental funding to mitigate COVID-19-related disruptions to federally funded research

The AAMC applauds Congress's longstanding commitment to medical research supported by the NIH, including recent emergency supplemental investments in essential COVID-19-related work. In response to the emergency, institutions have suspended research activities beyond critical and/or pandemic-related research, leading the vast majority of labs and clinical research nationwide to shut down. The PPE typically used for research activities is, in many cases, being given to clinical personnel to address existing or expected shortages. Research trainees, postdoctoral candidates, faculty, and research technicians who are not able to telework and rely on their grant funding for income could face financial stress. In addition, vital resources and research-related physical infrastructure, such as animal colonies and core facilities, need to be tended to even when research programs are suspended.

While NIH has provided helpful guidance and administrative flexibilities related to grants management, institutions and the research community will incur substantial expenses to support the research workforce as operations wind down temporarily, and again when ramping projects and labs back up once the crisis subsides.

The need for support to offset these research expenses is particularly acute, given the pressures the COVID-19 pandemic is placing on the nation's clinical enterprise, as well as on potential philanthropic and private foundation support. Because academic medical centers contribute, on average, an estimated additional $0.53 for every dollar of sponsored research support they

receive, many institutions rely on subsidies from clinical revenues to support the additional costs associated with the research mission. As stated previously, as a result of the pandemic, major teaching hospitals, health systems, and faculty physician practices are reporting significant financial losses. It is unlikely that providers will recover these losses, which will undermine the ability of teaching hospitals to continue supporting the costly research and education missions of their academic partners in the same way, and importantly, will not allow providers to take on additional research-related costs as a result of this national emergency. Similarly, given the economic toll of the crisis, it is not clear whether philanthropic contributions and support from private foundations will continue in the same way they did pre-COVID-19.

As you know, the U.S. medical research enterprise is crucial to developing treatments, cures, diagnostics, and preventions for existing and emerging diseases, and a robust research enterprise contributes to the nation's economic vitality. However, research programs cannot start or stop with the flip of a switch. Emergency support to mitigate the disruptions resulting from COVID-19 will help the nation's research enterprise recover as quickly as possible the momentum lost during the pandemic.

The AAMC joined members of the higher education community in an April 7 letter outlining areas of need for the research community supported by all federal research and development agencies. In addition to funding for new COVID-19-related research at NIH, the Agency for Healthcare Research and Quality, and other agencies, the AAMC specifically recommends that Congress:

- Provide emergency supplemental appropriations to NIH and other research agencies to support the research workforce, help institutions suspend and resume research projects, extend time for research projects once they resume, and support career transitions for graduate students and postdoctoral fellows.
- Allow extensions of the period of disbursement for RF1, UF1, and other multi-year grants to ensure awardees do not lose current funding and that grant deadlines do not expire while labs are closed.

Testing and Public Health

Invest in public health infrastructure

Both to enhance resilience against the current crisis and to prevent a potential recurrence of COVID-19 and the emergence of other future pandemics, robust investment in the nation's public health infrastructure, including the CDC, is necessary. Chronic underfunding has taken its toll on the nation's preparedness framework and under-resourced state and local health departments have been forced to manage a growing list of threats without commensurate support. For example, funding for the CDC's Public Health Emergency Preparedness (PHEP) program has dropped nearly 30% over the last two decades, while the Assistant Secretary for Preparedness and Response (ASPR)'s Hospital Preparedness Program (HPP) is funded at nearly half its FY 2004 funding level. Academic medical centers take seriously their role in emergency preparations and response, and a robust and strong public health infrastructure is necessary to optimize this work. Funding patterns that infuse resources only from crisis to crisis do not support a sustainable

preparedness strategy to keep the country safe and healthy. We need dramatically increased and sustained investments in these efforts.

Support the academic medicine community's efforts to maximize testing capacity
AAMC member teaching hospitals and medical schools have been at the front lines of the COVID-19 response, from patient care to developing and performing diagnostic tests. These institutions see the continued urgent need to substantially increase testing of both symptomatic and asymptomatic individuals to stop the spread of the virus and to inform an evidence-based timeline for returning to work. Unfortunately, many laboratories across the country continue to be severely hampered by shortages of needed reagents and supplies for testing. The federal government can help remedy some of these challenges by:

- Working quickly to deploy a web portal that would allow all laboratories to easily report reagent or other supply shortages that are slowing or preventing testing from occurring.
- Assuming a clearer role in the assessment and management of the supply chain for key testing reagents and supplies.
- Implementing a transparent communication system to inform vendors and labs about the priorities, directions, and specific needs of the community.

Enhance national COVID-19 data collection to better address health disparities
As the COVID-19 pandemic unfolds, the longstanding social, economic, and health inequities are being illuminated in the U.S. and across the globe. In the U.S., local data is showing that Black Americans are more likely to get sick and die from the novel coronavirus. This is not because the virus is naturally more harmful to racial and ethnic minorities. Rather, this is the result of policies that have shifted opportunities for wealth and health to a narrow segment of society putting those with fewer economic resources and with preexisting health conditions more at risk and vulnerable to illnesses like COVID-19. To address these shortcomings and to more effectively mitigate health inequities going forward, the AAMC recommends a data collection effort that is:

- National and standardized to accurately capture race and ethnicity data, as well as information on the social and environmental conditions in which people live, work, and play.
- Patient-centered and developed in collaboration with local community members and community-based organizations who have trusted and established relationships with local residents to identify communities disproportionally at-risk and to suggest structural interventions to ensure just, equitable preparedness and response during a pandemic.
- Reflective of the neighborhoods to which COVID-19 patients are discharged, noting that county or zip code data are not specific enough for densely populated communities likely to be most impacted by infectious disease.

Medical and Graduate Education

Maintain the US health and research workforce by extending visas, streamlining approval of new visas and changes of status, providing flexibility to sponsors in deploying visa holders where they are needed, expanding Conrad 30, and maintaining work authorization for Deferred Action for Childhood Arrivals (DACA) recipients

The U.S. health workforce and the patients it serves rely on physicians from other countries, particularly in rural and other underserved communities. Their role is amplified each year as the nation faces growing physician workforce shortages and acutely during the COVID-19 national emergency. This year, thousands of physicians from other countries already in the U.S., and more than 4,200 who just matched to medical residency programs at U.S. teaching hospitals, will encounter significant barriers to enter or remain in the country (typically on H-1B and J-1 visas).

As most medical residency programs start around July 1, a predictable and timely visa application process is paramount. These physicians frequently use the State Conrad 30 J-1 Visa Waiver program to practice in rural and underserved areas. Furthermore, more than 27,000 medical professionals are at risk of losing their work authorization under the (DACA) program at the peak of the COVID-19 pandemic pending the U.S. Supreme Court decision.

In addition, a significant proportion of the U.S. research workforce, including the majority of biomedical postdoctoral researchers, is composed of international scholars, but the ability to obtain visas and travel is severely restricted during the pandemic. Many postdoctoral scholars who had secured positions in the U.S. are delayed in entering the country. This restriction of the scientific workforce will cause both short- and long-term stress on the U.S. research workforce pipeline and could significantly impact our country's ability to attract the best and brightest scholars.

In light of the country's significant reliance on these providers and researchers, AAMC urges Congress to:

- Pass the Conrad State 30 and Physician Access Act (H.R. 2895/S. 948), which would reauthorize and expand the State Conrad 30 J-1 visa waiver program to help underserved communities.
- Pass the American Dream and Promise Act of 2019 (H.R. 6) or the Dream Act of 2019 (S.874), which would provide a pathway to citizenship for certain undocumented individuals, including many health professionals with DACA status who are currenting treating COVID-19 patients.

Additionally, the AAMC urges the administration to:

- Temporarily extend nonimmigrant status for physicians and medical residents through the COVID-19 national emergency to allow them to continue to treat patients in the U.S.
- Expedite approvals of extensions and changes of status for physicians and medical residents practicing or otherwise lawfully present in the U.S.
- Resume H-1B premium processing for physicians and medical residents to facilitate expedited processing.

- Temporarily allow physicians and medical residents (including those on J-1 and H-1B visas, such as participants in the Conrad 30 program) to be redeployed to additional locations, as needed, to respond the COVID-19 pandemic.

Invest in health professions students and provide tax relief to students, medical schools, and hospitals

The AAMC appreciates that Congress designated $12.6 billion for institutions of higher education in the CARES Act's Education Stabilization Fund, recognizing the financial impact the coronavirus pandemic has levied on colleges and universities. However, independent health professions schools are underrepresented in the current formula since their student bodies primarily consist of graduate and professional students who are not eligible for Pell Grants. As a result, these institutions will receive disproportionately less funding to help their students during the pandemic. The AAMC urges Congress to increase the Education Stabilization Fund and adjust the formula to help the next generation of providers who will respond to future public health crises. Furthermore, AAMC supports loan forgiveness for health professionals in high-need areas during the COVID-19 pandemic and to prepare the workforce to respond to future threats, particularly in underserved areas and specialties.

To help alleviate the financial burden on students and families currently in distress, the AAMC urges Congress to suspend the taxation of grant aid used on non-tuition expenses like room and board as a form of unearned income. Suspending the taxability of scholarship and grant aid would permit low- and middle-income students to retain more of this aid, including any student aid provided under the COVID-19 supplemental packages.

As academic medical centers are facing significant revenue losses, AAMC urges Congress to repeal the excise tax on investment income of private colleges and universities, known as the "endowment tax." This will free up vital resources for institutions to assist student and family needs during this time, as well as to continue necessary operations to keep training future physicians.

Finally, the Families First Coronavirus Response Act (P.L. 116-127) expanded paid sick leave and paid family and medical leave for many employers, including many private and all public employers. To help employers pay for these leave provisions, Congress created a refundable tax credit, which pubic institutions are not eligible to receive.

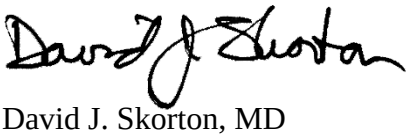
To support health professions schools and the graduate and professional students who will be on the front lines of future pandemics, the AAMC urges Congress to:

- Increase investments in the Education Stabilization Fund and adjust the formula to support the next generation of providers.
- Suspend the taxation of grant aid used on non-tuition expenses like room and board as a form of unearned income.
- Repeal the excise tax on investment income of private colleges and universities.

- Expand the tax credit to include public institutions, to help make sure public hospitals and medical schools are reimbursed for providing leave to those impacted by the COVID-19 outbreak.

Again, the AAMC appreciates your efforts to combat COVID-19, and we will continue partnering with you in this response. Should you have any additional questions, please do not hesitate to contact me directly or AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org).

Sincerely,



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