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July 19, 2021

The Honorable Diana DeGette
United States House of Representatives
Washington, DC 20515

The Honorable Fred Upton
United States House of Representatives
Washington, DC 20515

Dear Representatives DeGette and Upton:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments on the recently unveiled Cures 2.0 Act discussion draft, which would build on your landmark 21st Century Cures Act efforts to modernize health care coverage, ensure access to scientific breakthroughs, and prepare for future pandemics. The AAMC supports these efforts and will work with our members, policymakers, and other health care stakeholders to participate in and provide input to this important conversation.

The AAMC is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC was pleased to support the 21st Century Cures Act and commends your efforts to build upon that landmark legislation. In particular, the AAMC is incredibly grateful that the Cures 2.0 Act includes legislation to protect previous investments in medical research and the future research workforce from the harmful impacts of the COVID-19 pandemic. The AAMC has endorsed the Research Investment to Spark the Economy (RISE) Act and is grateful for your leadership in working to restore pre-pandemic momentum in the nation's scientific enterprise. This provision takes an important step in preserving our nation's investment in research across federal science agencies and in ensuring that we do not lose ground in innovation and discovery or turn away a generation of future biomedical researchers. Research recovery will be key to supporting the research enterprise and its workforce in resuming operations and completing research studies that have already received substantial federal investments. The nation's economic vitality and global competitiveness are both favorably enhanced by the federal commitment to research, and a thriving, diverse national science agenda also is essential to help the nation address the current crisis and build resilience against future threats. We are grateful that you are championing these needs as a key priority and for your ongoing efforts to secure funding support.

Please see below our more specific feedback on the discussion draft from internal experts at the AAMC.

One overarching recommendation we wish to highlight throughout the bill is to ensure that any federal programs or convenings authorized in this legislation consider who is missing from the table at the outset to ensure there is adequate representation of voices, perspectives, experiences, and

concerns from design to implementation. Such an approach will be key to promote diversity of ideas and reinforce a commitment to reduce inequities, a high priority for the AAMC and its member medical schools, teaching physicians, teaching hospitals, and scientists.

In addition to the comments here, the AAMC is pleased to provide feedback on the proposed Advanced Research Agency Projects for Health (ARPA-H) initiative, and we are responding to the related request for information through a separate letter. The AAMC looks forward to continuing to be a resource to you and your staff as you finalize the Cures 2.0 Act.

Title I: Public Health

Sec. 101. Further Understanding the Implications of Long COVID

The AAMC supports efforts to better understand the long-term public health consequences of COVID-19, including ongoing efforts supported by the NIH to understand the long-term health effects of COVID-19 ("long COVID or long haulers") through the RECOVER Initiative: REsearching COVID to Enhance Recovery. Even as successful vaccination campaigns have led to lower rates of new infections and hospitalizations in many communities across the country, medical schools and teaching hospitals continue to leverage their medical research and clinical care missions in addressing long COVID. Many academic medical centers quickly opened new clinics and launched research efforts to better understand and treat the lingering effects of the SARS-CoV-2 virus in some individuals. Our members report that these multidisciplinary clinics are fully booked for months out, demonstrating the substantial demand for such an emphasis, as patients grapple with a constellation of symptoms ranging from cognitive impairment and fatigue to respiratory challenges, muscle weakness, and persistent loss of taste and smell months after the infection.

To complement these ongoing efforts to understand and respond to the biological and clinical long-term implications of COVID-19, it will also be necessary to understand the impact of long haulers on the health systems and providers. For example, it will be critical to understand what will be needed to support these patients, what programs may need additional investments, and how those needs may require health care providers to change how they deliver care for these patients.

With their breadth of expertise and experience, representatives from academic medicine are particularly well suited to participate in the Learning Collaborative that would be established under Section 101 to better understand and address the long-term impacts of COVID-19 on patients and communities. For example, our minority-serving institutions have the expertise, collaborative community partnerships, and key stakeholder relationships to inform discussions about the long-term implications of COVID-19, prevention strategies, and health care continuity in communities that have been disproportionately affected by COVID.

In addition to participation from academic medicine, we recommend that the proposed efforts include a focus on the communities that have been most severely impacted by COVID-19, including engaging patients themselves in the planning process. A better understanding of the root causes of health-related disparities is necessary to better address long term impacts on the most vulnerable communities and to promote equitable prevention efforts.

Sec. 102. National Testing and Response Strategy for Future Pandemics

The AAMC appreciates the discussion draft's focus on improving the country's medical and public health preparedness for future pandemics. Enhancing our national resilience against the next pandemic is a high priority for the AAMC. In fact, we recently submitted an extensive set of

recommendations to the House Energy and Commerce Committee leadership based on academic medicine's experiences throughout the COVID-19 public health emergency. Our communication includes several recommendations related to a national testing and response strategy, including bolstering the nation's genomic sequencing infrastructure for surveillance; the importance of a coordinated federal response with input from academic medicine and its community partners; strengthening the Strategic National Stockpile and testing infrastructure and establishing complementary mechanisms to ensure adequate supply; ensuring geographic diversity of vendors; and addressing testing and vaccination delivery barriers in underserved communities. We welcome the opportunity to engage further with you on opportunities to address these critical needs.

Sec. 104. Vaccine and Immunization Programs

The pandemic has illustrated clearly the limitations of outdated public health data systems at the national, state, and local levels, as well as within individual facilities and institutions. Antiquated, incompatible, inconsistent, and incomplete systems impeded multiple dimensions of the nation's COVID-19 response, including information exchange related to immunization programs. There needs to be a coordinated and national plan for tracking vaccinations so that individual states have registries that are standardized, communicate across state lines, and are accessible to patients and providers. This is going to be very important in planning for and responding to the possible need for booster doses and for future pandemics. The AAMC supports additional, sustained investments in data modernization, including to support immunization information systems as proposed in the discussion draft, and we are aware of legislation, such as the Immunization Infrastructure Modernization Act (H.R. 550), to strengthen the infrastructure for future vaccine campaigns.

Beyond the provisions outlined in the discussion draft, we wish to highlight other key considerations related to vaccines. In addition to their central role in the research that led to the three currently authorized vaccines in the U.S., academic medical centers have actively been working with their communities to administer vaccines and promote vaccine confidence. Some of this work is supported by a cooperative agreement between the AAMC and the Centers for Disease Control and Prevention (CDC): Improving Clinical and Public Health Outcomes through National Partnerships to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats. The funded work focuses on engaging health care personnel across academic health systems to positively impact vaccine confidence, particularly in communities disproportionately impacted by COVID-19. Ongoing support for such engagement is critical.

Additionally, prior to the next major pandemic threat, there needs to be a process in place defining how jurisdictions and providers will receive diagnostics, treatments, vaccines, and/or supplies, and what the federal government's expectations are for how states allocate and track use of these resources, with a focus on equitable and need-based distribution. In the COVID-19 experience, the federal government relied heavily on state governments for the development of state-specific testing goals, reopening strategies, and allocation of scarce resources such as initial allotments of the vaccines. This decentralized approach resulted in inconsistencies and planning challenges for both states and health care providers. Differing policies and procedures in different states resulted in confusion and led to increased public distrust of health care and governmental entities. In addition, many states have not maintained their public health infrastructure, so turning to state governments for local guidance was, in some cases, ineffective. More clarity from the federal government was needed and will be needed in future epidemics.

Guarding against inequities should also be a top priority. One glaring example of how inequities manifested during COVID-19 is in access to diagnostics and countermeasures. Mobile units can help

fill these gaps by bringing resources to the community rather than forcing the community to find the resources. The AAMC supported the Mobile Options for Testing In Our Neighborhoods (MOTION) Act in the 116th Congress, which would authorize grants to academic medical centers, health centers, health departments, and nonprofit organizations to establish or expand mobile COVID-19 testing initiatives, and funding for similar efforts in the American Rescue Plan has helped advance state and federal vaccination efforts. Grants to establish, equip, and deploy truly mobile testing and vaccination units to serve hard-to-reach populations would be particularly effective if implemented with a commitment to community engagement, with grantees working in partnership with community-based organizations and leaders to develop resources, conduct outreach and program evaluations, and take other steps to understand and meet the community's needs. Such programs serve as an important complement to other ongoing efforts to increase the availability and accessibility of testing, vaccinations, and other key outreach, and to address and resolve health inequities.

Sec. 105. Developing Antimicrobial Innovations

The AAMC appreciates your recognition of antibiotic resistance as a significant public health concern. We support the approach to incentivize drug development and antibiotic and diagnostic stewardship through the inclusion of the Pioneering Antimicrobial Subscriptions to End Up Surging Resistance (PASTEUR) Act in the Cures 2.0 Act.

Title II: Patients and Caregivers

Sec. 201. Educational Programs and Training for Caregivers and Sec. 202. Increasing Health Literacy to Promote Better Outcomes for Patients

The AAMC acknowledges the importance of training caregivers as a complement to clinical care. We support the Geriatric Workforce Education Program, an existing program administered by the Health Resources and Services Administration (HRSA) under Title VII of the Public Health Service Act, which provides funding to train caregivers for older Americans. We caution against the creation of a duplicative program through the Cures 2.0 Act.

The AAMC praises the efforts of the discussion draft to increase health literacy for patients. Studies have shown that informed patients have better health outcomes.[1,2] Additionally, health literacy and digital literacy and the intersection of the two are major barriers to telehealth utilization.[3,4] We agree that exploring strategies to increase patient health literacy would be beneficial, and we would encourage taking a community informed and culturally appropriate approach to health literacy promotion efforts. Of note, there are internet access gaps among marginalized population groups,

[1] Paterick, T. E., et al. (2017). Improving health outcomes through patient education and partnerships with patients. *Proceedings (Baylor University. Medical Center)*, *30*(1), 112–113. https://doi.org/10.1080/08998280.2017.11929552

[2] Sepucha, K. R., et al. (2018). Informed, Patient-Centered Decisions Associated with Better Health Outcomes in Orthopedics: Prospective Cohort Study. *Medical decision making : an international journal of the Society for Medical Decision Making*, *38*(8), 1018–1026. https://doi.org/10.1177/0272989X18801308

[3] Schifeling, C. H., et al. (2020). Disparities in Video and Telephone Visits Among Older Adults During the COVID-19 Pandemic: Cross-Sectional Analysis. *JMIR aging, 3*(2), e23176. doi: 10.2196/23176

[4] Franciosi, E. B., et.al. (2021). The Impact of Telehealth Implementation on Underserved Populations and No-Show Rates by Medical Specialty During the COVID-19 Pandemic. *Telemedicine journal and e-health : the official journal of the American Telemedicine Association*. doi: 10.1089/tmj.2020.0525

including individuals with disabilities. Those with a lower socioeconomic status are more likely to depend on smartphones which could affect utilization and ultimately health outcomes.[5] While the essential technological needs like device and internet access may be lacking, even with these necessities available there are demonstrable differences in the efficacy of telehealth based on age, ethnicity, and language.

Sec. 203. Increasing Diversity in Clinical Trials

The AAMC is supportive of efforts to increase racial and ethnic diversity in clinical trials and urges close attention to trial designs that encompass racism as a social construct and do not perpetuate race-based medicine. The coronavirus pandemic has illuminated the social, economic, and health inequities in the United States which have resulted in COVID-19 having a devastatingly disproportionate impact on communities of color. Sadly, these hindrances to equitable health and health care are not limited to COVID-19. We appreciate that this bill would encourage federal agencies to take meaningful steps independently and in partnership to engage marginalized racial and ethnic groups in research and clinical trials participation, to better understand and address barriers that may prevent diverse participation in clinical trials, and to ensure a more user-friendly experience for clinical trials participation.

Through their missions of education, research, clinical care, and community collaboration, the nation's medical schools and teaching hospitals and health systems have responded, and continue to respond, to the ongoing public health crisis for all the communities they serve. They stand ready to partner with community groups and the federal government to build trust and facilitate clinical trials participation by communities of color. The AAMC encourages community participation in the design, implementation, and evaluation of clinical research and recommends specific inclusion of local community partners in discussions regarding improving public awareness of clinical trials opportunities and the utility of ClinicalTrials.gov.

Relatedly, the AAMC Center for Health Justice, in partnership with community stakeholders, recently released *10 Principles of Trustworthiness* and a corresponding toolkit to guide organizations, including government entities, in their efforts to equitably partner with communities and build trust among members of those communities. The principles and toolkit, which reflect core tenets of bidirectional learning and shared leadership, integrate local perspectives around trust, COVID-19, and clinical trials participation, with established precepts for community engagement.

Sec. 205. Ensuring Coverage for Clinical Trials Under Existing Standard of Care

The AAMC strongly supports the Patient-Centered Outcomes Research Institute (PCORI) and appreciates the discussion draft's attention to coverage for PCORI-funded clinical trials.

Title III: Food and Drug Administration

Sec. 301. Report on Collaboration and Alignment in Regulating Digital Health Technologies

When developing digital technologies to improve health care, it is important to also consider how innovations may exacerbate health disparities and understand their influence on patient engagement. Efforts to advance digital technologies in health care should also account for populations with low

[5] Pew Research Center. (2021, April 27). *Internet/Broadband Fact Sheet.* https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?menuItem=194b49c6-68e6-45f0-902a-575673edb17f

literacy, limited English proficiency, and inadequate internet access that may make engagement with electronic platforms more difficult.

Research has shown that health care providers' explicit and implicit biases disadvantage racial and ethnic minorities in the health care system and must be accounted for when devising new technologies to ensure relevant information is present, appropriately represents diverse populations, and fosters enhanced patient-provider relationships.[6,7] Research has also shown that minority and underserved populations are less likely to participate and engage with health technology due to mistrust.[8] To improve levels of trust and uptake, we recommend that Congress incentivize health IT vendors and developers to engage with minority-serving community organizations during the design, implementation, elevation, refinement, and dissemination of digital health technologies. As noted above, the AAMC Center for Health Justice Principles of Trustworthiness Toolkit can serve as a useful tool to help federal agencies facilitate discussions and develop strategies with community members to address pervasive issues, including ongoing inequities in awarding contract and subcontracts.

Sec. 302. Grants for Novel Trial Designs and Other Innovations in Drug Development and Sec. 304. Increasing Use of Real-World Evidence

Targeted medications and technologies are being approved with smaller clinical trials and are coming to market sooner. Some of these therapies have limited to no benefit over current technologies, yet many of these therapies continue to command high list prices upon entry into the market, with substantial price increases over time. As Congress looks to address high drug prices, investment in improved post-market surveillance of these new technologies that includes the use of real-world patient experiences should be expanded to evaluate long-term clinical effectiveness of approved drugs and technologies and to inform coverage decisions in federal programs.

The emphasis on post-approval real-world evidence should not substitute for the thorough, deliberative process the Food and Drug Administration (FDA) must undertake prior to the approval of a new therapy. The AAMC fully supports the use of real-world evidence to better understand how an approved product functions outside of the narrow confines of a clinical trial but does not believe that the FDA should approve new products in a more cursory manner with the promise that future real-world evidence gathering would be used to support or reverse a decision.

Sec. 305. Improving FDA-CMS Communication Regarding Transformative New Therapies

The AAMC is generally supportive of encouraging productive and collaborative communication between the FDA and the Centers for Medicare and Medicaid Services (CMS), especially in the context of accelerated approvals of promising new therapies. While the two agencies' responsibilities are distinct and safety and efficacy determinations should remain separate inquiries from coverage determinations, the AAMC recognizes that an accelerated process by FDA will only speed up access to that new therapy with its subsequent coverage. Knowing that such a product is likely to be entering the market will allow CMS to undertake its own analysis for coverage purposes. Nothing in

[6] Brewer, L. C., et.al. (2020). Back to the Future: Achieving Health Equity Through Health Informatics and Digital Health. *JMIR mHealth and uHealth*, *8*(1), e14512. https://doi.org/10.2196/14512

[7] Christopher Gibbons M. (2011). Use of health information technology among racial and ethnic underserved communities. *Perspectives in health information management*, *8* (Winter), 1f.

[8] Bagchi, Ann, et al. (2007). Considerations in Designing Personal Health Records for Underserved Populations. Princeton, NJ: Mathematica Policy Research.

this communication requirement should suggest that CMS's intention to cover the therapy should be determinative in FDA's approval process.

Title IV: Centers for Medicare & Medicaid Services

Sec. 402. Strategies to Increase Access to Telehealth under Medicaid and Children's Health Insurance Program and Sec. 403. Extending Medicare Telehealth Flexibilities

The AAMC appreciates and supports the inclusion of policies in this discussion draft to expand access to telehealth services for patients beyond the COVID-19 public health emergency (PHE). The current telehealth flexibilities help ensure that providers can continue to deliver quality health care for patients during the PHE. Many of these flexibilities have proven to expand access to care and should continue to be integrated into the health care system beyond the end of the PHE.

Teaching hospitals, faculty physicians, and other providers have responded to the PHE and the waivers and flexibilities provided by Congress and the administration by rapidly implementing telehealth in their settings and practices in order to provide continued access to medical care for their patients. Telehealth provides both patients and providers with a variety of benefits and expands access to care, including increased access to specialist care, while also achieving high patient satisfaction.

The AAMC supports the provisions in the Telehealth Modernization Act (H.R. 1332), introduced by Reps. Buddy Carter (R-Ga.) and Lisa Blunt Rochester (D-Del.), which would permanently remove patient location and rural site requirements to allow Medicare beneficiaries to access telehealth visits in any location. These temporary changes have allowed patients to remain in their home and reduce their exposure to COVID-19. Maintaining such changes after the end of the PHE would allow patients who have difficulty traveling to an in-person appointment to receive vital care, especially elderly patients and those with chronic conditions or disabilities that require regular monitoring.

Additionally, the AAMC supports the inclusion of the Telehealth Improvement for Kids' Essential Services Act (TIKES Act, H.R. 1397), introduced by Reps. Lisa Blunt Rochester (D-Del.) and Michael Burgess, MD, (R-Texas) to provide states with guidance and strategies to increase telehealth access for patients with coverage through Medicaid and the Children's Health Insurance Program (CHIP).

In addition to the policies included in this discussion draft, the AAMC encourages Congress to permanently extend other telehealth flexibilities that have been implemented in response to the COVID-19 pandemic, including reimbursing providers the same amount for telehealth services as in-person visits, allowing Medicare payment for audio-only services, and allowing patients to access telehealth services across state lines as appropriate.

The AAMC also urges lawmakers to make telehealth flexibilities permanent to support clinical trials in addition to clinical care. To maintain social distancing and prevent unnecessary visits to hospitals and clinics, many researchers, with the support of institutions, industry sponsors, and institutional review boards (IRBs), adapted clinical trial protocols to continue their research while addressing the safety of research participants. Researchers adopted new electronic processes and procedures to speed the initiation of research, promote the ease of IRB review and data sharing, and reduce contract negotiation turn-around time. Specifically, utilizing telehealth to collect research participant consent and conduct follow up assessments that did not require procedures or interventions increased efficiency of the clinical trial enrollment process and was viewed favorably by participants and

researchers alike. In addition to the clinical care benefits, the AAMC urges lawmakers to make the telehealth flexibilities permanent to help improve the efficiency of clinical trials and improve the experience of clinical trial participants.

Sec. 404. Coverage and Payment for Breakthrough Devices Under the Medicare Program

The AAMC supports making breakthrough technology available to the Medicare population as quickly as is reasonable but has significant concerns regarding the CMS proposal that in general, automatically provides coverage for a device that has FDA approved marketing and FDA designation as a breakthrough device. Because Medicare beneficiaries often are underrepresented in clinical trials, the safety and effectiveness of devices and other items and services for the Medicare population may be unknown. It is important to ensure that easier access to breakthrough technology is paired with adequate protections for Medicare beneficiaries. For example:

- Device manufacturers should be required to submit data, whether from ongoing clinical trials or from other sources, such as claims data.
- CMS should regularly monitor and analyze all available data and make it available to researchers. In the event that the data show that Medicare beneficiaries are being harmed by the device, or other concerns are raised, the agency should determine whether the device should be withdrawn from the Medicare Coverage and Innovative Technology (MCIT). We do not believe any device should be guaranteed four years in the MCIT.
- The MCIT should apply to breakthrough devices only and should be limited to the FDA indication that received breakthrough designation. Once CMS has sufficient experience with the program, the agency can determine whether to undertake another rulemaking to expand it to certain drugs and biologicals.
- CMS should be required to engage with stakeholders to develop a method that expedites the availability of breakthrough devices while continuing to offer Medicare beneficiaries the protections they expect from the program.

Sec. 405. Secretary of Health and Human Services Report on Coverage for Innovative Technologies

As you proceed, it is important that any discussion of innovative technologies also address the issue of non-digital, high-cost technologies that have the potential to dramatically improve patients' health and quality of life. Chimeric Antigen Receptor (CAR) T-cell immunotherapy is an example of a high-cost, innovative technology that is changing lives. However, current Medicare reimbursement for CAR T-cell treatments is inadequate. Cutting-edge treatments such as CAR T-cell immunotherapy are performed almost exclusively at teaching hospitals that already struggle with negative Medicare margins. As new and innovative cures come to market, Congress must fully consider the disproportionate burden faced by teaching hospitals because of those payments, which jeopardizes beneficiary access to these life-saving treatments.

Sec. 407. Expanding Access to Genetic Testing and Sec. 408. Medicare Coverage for Precision Medicine Consultations

The AAMC is supportive of increased access to genetic testing for certain pediatric rare disease patients and expanded Medicare coverage for precision medicine consultations to develop patient-specific treatments and improve health outcomes. Medicare coverage should clearly distinguish a precision medicine consult from a regular consult.

Title V: Research

Sec. 501. Advanced Research Projects Agency for Health and Sec. 502. Research Investment to Spark the Economy

The AAMC is pleased to provide feedback on the proposed ARPA-H initiative and is addressing the related request for information through a separate letter.

Additionally, as mentioned above, the AAMC is incredibly grateful that the Cures 2.0 Act discussion draft includes legislation to protect previous investments in medical research and the research workforce from the harmful impacts of the COVID-19 pandemic. The AAMC has endorsed the Research Investment to Spark the Economy (RISE) Act and is grateful for your leadership in working to restore pre-pandemic momentum in the nation's scientific enterprise.

Other Considerations

Research Policy Board

One of the key recommendations of the 2016 report from the National Academies of Sciences, Engineering, and Medicine "Optimizing the Nation's Investment in Academic Research" was the formation of a Research Policy Board, a recommendation that we appreciate was incorporated into the 21st Century Cures Act. This body, comprised of federal and non-federal members, was intended to make recommendations "regarding the modification and harmonization of regulations and policies having similar purposes across research funding agencies to ensure that the administrative burden of such research policy and regulation is minimized to the greatest extent possible and consistent with maintaining responsible oversight of federally funded research." This essential function to streamline regulations and minimize burden has not been implemented, and we suggest that Cures 2.0 could include a mechanism to ensure the formation of the Research Policy Board as already directed by Congress.

Support Research Lessons Learned from COVID-19

During the COVID-19 response, NIH's National Center for Advancing Translational Sciences played an important role to unite clinical researchers from across the country to build the National COVID Cohort Collaborative (N3C). This clinical data repository contains standardized electronic health record data for more than 6 million patients and is currently supporting more than 200 research projects. It is the largest clinical data repository in country, and represents a large, unified effort made by the biomedical research community to respond to the pandemic. We urge you to consider additional funding to maintain this valuable resource to aid in the continued COVID-19 response, to better understand long-term health complications of COVID-19, and to more quickly respond to future pandemics.

Increase Federal Support for Physician Training

The AAMC projects that the United States will face a shortage of between 37,800 and 124,000 physicians by 2034, in both primary care (between 17,800 and 48,000) and specialty care (between 21,000 and 77,100). Additionally, if everyone had the same health care access and utilization rates regardless of race, where they live, and whether they have health insurance, the AAMC estimates the country would need up to an additional 180,400 doctors today, on top of the projected shortages by 2034. These shortages strain patients' abilities to access timely care under even the best of circumstances, but the consequences of such deficits are particularly acute during a crisis.

COVID-19 laid bare these shortages of crucial providers, including infectious disease specialists, but also the overall shortage of physicians as doctors were called to the front lines of COVID-19 sometimes regardless of their specialty. Also laid bare by COVID-19 are the acute racial and ethnic health disparities. A diverse health care workforce contributes to culturally responsive care, helps to mitigate bias, and improves access and quality of care to reduce these health disparities. It also improves primary care and access as underrepresented students are more likely to choose primary care specialties.

The major factor driving demand for physicians continues to be the country's growing, aging population. With the demand for physicians simply outstripping our expected supply, we must advance a multifaceted strategy to ensure that people have access to the care they need when they need it. A broad bipartisan coalition of members of Congress representing diverse districts, states, and communities worked together last year to provide 1,000 new Medicare-supported graduate medical education (GME) positions in the Consolidated Appropriations Act, 2021– the first increase of its kind in nearly 25 years. This historic increase in residency positions was an important initial investment and first step, but more is needed to help ensure that patients throughout the country can access the primary and specialty care they need and a diverse physician workforce. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2021 (H.R. 2256, S. 834) which would build upon last year's bipartisan effort and increase teaching hospitals' ability to train physicians by gradually lifting the current effective freeze on Medicare support and adding 14,000 new Medicare-supported residency positions over the next seven years.

Thank you again for your efforts to build upon the 21st Century Cures Act and ensure patient access to new cures and innovative therapies. We welcome the opportunity to expand on the information we have provided above and serve as a resource to you as you continue these efforts. Please feel free to contact Christa Wagner, PhD, Senior Legislative Analyst, at chwagner@aamc.org, or me, with any questions.

Sincerely,

Karen Fisher, JD
AAMC Chief Public Policy Officer