



**Association of
American Medical Colleges**
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Aug. 27, 2021

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives

The Honorable Charles Schumer
Majority Leader
U.S. Senate

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives

The Honorable Mitch McConnell
Minority Leader
U.S. Senate

Dear Speaker Pelosi, Majority Leader Schumer, Leader McCarthy, and Leader McConnell:

On behalf of the AAMC (Association of American Medical Colleges), I write to urge you to improve the health of patients and communities through investing in key programs that support the nation's health care, research, and public health infrastructure and promote health equity in the forthcoming Build Back Better Act. We were pleased to see that the budget reconciliation instructions include many of these priorities and we support their inclusion in the final package. Specifically, we encourage you to:

- Invest in expanding and diversifying the physician workforce by increasing the number of Medicare-supported graduate medical education (GME) positions.
- Increase access to high-quality, affordable health care coverage by strengthening the Affordable Care Act (ACA) and addressing the Medicaid coverage gap.
- Strengthen our public health and health care infrastructure to better prepare for future pandemics.
- Provide funding to enhance research infrastructure and to mitigate the impact of the current pandemic on the research workforce and broader research enterprise.
- Ensure standardized, valid, and inclusive data collection to address pervasive health inequities laid bare by the pandemic's disproportionate impact on communities of color.
- Provide permanent residence status for DACA recipients and expand the Conrad 30 program.

The AAMC is a nonprofit 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; approximately 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 the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Physician Workforce and Graduate Medical Education

The COVID-19 pandemic has reinforced that physicians are a critical component of our nation's health care infrastructure, and we must train more to meet both the current and future needs of our nation. The pandemic has also exposed the significant barriers to accessing a physician that patients face and highlighted rising concerns of physician burnout and early retirements. Additionally, as our population grows and ages, the demand for physicians continues to grow faster than the supply, resulting in an estimated shortfall of between 37,800 and 124,000 specialty and primary care physicians by 2034.¹

Last year, Congress provided 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act, 2021 – the first increase of its kind in nearly 25 years. This increase in residency positions was an important initial investment and first step, but more is needed to help ensure a larger and more diverse physician workforce to help patients throughout the country access the primary and specialty care they need.

To help meet this growing need, a broad bipartisan coalition of House and Senate health care leaders representing diverse districts, states, and communities introduced the *Resident Physician Shortage Reduction Act of 2021* (S.834/H.R. 2256), which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. Much like the 2020 year-end package, these positions would be targeted to teaching hospitals with diverse needs including teaching hospitals in rural areas, teaching hospitals serving patients from health professional shortage areas, teaching hospitals in states with new medical schools or branch campuses, and teaching hospitals already training over their Medicare caps.

Another critical component to rebuilding the nation's health care infrastructure is an expansion of health care workforce programs that will be integral to addressing health care equity and training a more diverse, culturally competent physician workforce. While existing pathway programs play a crucial role in cultivating a more diverse workforce, more must be done to increase physician diversity. The *Resident Physician Shortage Reduction Act of 2021* takes an important step in addressing this challenge by commissioning a report to specifically look at ways to create a more diverse clinical workforce.

Access issues persist in rural and underserved communities, and it is paramount that we direct resources where they are needed most. Additional Medicare-supported GME positions allow teaching hospitals to expand their training programs and can help them take advantage of programs that diversify the resident experience, such as Rural Training Track programs, which rotate residents training in urban hospitals into rural hospitals.

¹ *The Complexities of Physician Supply and Demand: Projections from 2019-2034*, Association of American Medical Colleges: <https://www.aamc.org/media/54681/download>

The physician workforce mirrors our aging society and, in 2019, nearly 45% of active physicians in the United States were age 55 or over.² As the country recovers from the COVID-19 pandemic and begins to prepare for planned (and unplanned) physician retirements and long-term health care impacts of the pandemic, it is evident that investments in the physician workforce infrastructure are vital to the country's health. The *Resident Physician Shortage Reduction Act of 2021* would help alleviate the physician shortage, ensure that patients have access to the care they need, take steps towards diversifying the physician workforce, and better prepare the nation to tackle future health care crises. It is imperative that this legislation be included in the reconciliation package so that the nation can bolster this critical part of our health care infrastructure.

Additionally, programs administered by the Health Resources and Services Administration, such as the National Health Service Corps (NHSC) and Teaching Health Centers GME (THCGME), seek to increase the number of physicians practicing at Federally Qualified Health Centers and in rural areas. The AAMC supports continued growth for the NHSC and THCGME programs to recruit physicians to serve our most vulnerable patients in rural and other underserved communities.

Health Care Access and Coverage

The AAMC is dedicated to improving the health of people everywhere. We believe that everyone should have access to high quality, affordable, and comprehensive health care coverage. The ACA has drastically reduced the number of uninsured Americans and Congress and the Biden Administration have taken important steps to continue to expand access to health care.

The American Rescue Plan Act (ARP) included provisions that temporarily enhance the Marketplace subsidies and make them available to more Americans. Under the ARP, anyone who earns up to 150% of the federal poverty level (FPL) or who received an unemployment insurance payment in 2021 will have no cost-sharing requirement. Those with incomes above 400% of the FPL will contribute no more than 8.5% of their income towards premiums, regardless of their income. These enhanced subsidies are currently available through 2022. The AAMC encourages Congress to permanently extend these subsidies in the reconciliation package to help more low and middle-income individuals and families afford high-quality health insurance.

The ACA also expanded Medicaid coverage for most nonelderly adults with incomes up to 138% of the FPL. While the law anticipated nationwide implementation, the Supreme Court's decision in 2012 effectively made expansion optional for states. To date, 39 states (including Washington, DC) have opted to expand their Medicaid program to cover this population. Medicaid expansion

² 2020 *Physician Specialty Data Report*, Association of American Medical Colleges: <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-age-and-specialty-2019>

has provided nearly 15 million low-income adults with low-to-no-cost, affordable, comprehensive coverage.³

Despite this progress, 2.2 million adults in the remaining 12 non-expansion states fall into the coverage gap and are uninsured because they have incomes too low to qualify for subsidized health insurance coverage in the Marketplace but too high to qualify for their states' Medicaid program.⁴ Communities of color are disproportionately uninsured, especially in these non-expansion states. Black and Latino adults represent more than half of all adults that remain uninsured in the Medicaid coverage gap in non-expansion states, despite representing only 36% of adults within these states.⁵

It is critical to cover the uninsured population since those without health coverage are more likely to suffer declines in their overall health, have poorer health outcomes, and face delays in care due to cost barriers that can result in health emergencies and hospitalizations.⁶

To address this issue, we urge Congress to adopt a federal coverage option for the remaining uninsured population in non-expansion states. This could involve the federal government offering “look alike” Medicaid coverage or leveraging the Marketplace for adults with incomes less than 138% of the FPL in states that have not yet expanded Medicaid.

The AAMC was also pleased to see that the ARP included a state plan option to expand Medicaid and Children's Health Insurance Program coverage for pregnant women to one-year post-partum from the current 90 days. Access to care is a critical component to improving outcomes for any and all patients, not just new birthing persons; but it is clear that this loss of post-partum coverage in particular imposes a hurdle to accessing needed care.

More than 70% of new birthing persons experience complications in the year after childbirth, and while not all complications result in a fatality, of the fatalities that do occur, approximately three in five were preventable.⁷ Rates of severe morbidity are significantly higher in racial and ethnic minority women than in white women.⁸ Coupled with the fact that nearly 50% of births are to women covered by the Medicaid program, and that Medicaid covers a greater share of births in rural areas and among minority women, it is clear that expanded Medicaid coverage for new birthing persons up to one year postpartum could have marked effects on preventing maternal deaths.⁹ The AAMC urges you to make this a permanent requirement for all states.

³ <https://data.medicaid.gov/Enrollment/2021-1Q-Medicaid-MBES-Enrollment/379c-k6ss/data>

⁴ <https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial>

⁵ <https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial>

⁶ <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

⁷ Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. *MMWR Morb Mortal Wkly Rep* 2019;68:423–429. DOI: <https://dx.doi.org/10.15585/mmwr.mm6818e1>

⁸ Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clinical obstetrics and gynecology*, 61(2), 387–399. <https://doi.org/10.1097/GRF.0000000000000349>

⁹ <https://www.macpac.gov/wpcontent/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf>

Pandemic Preparedness

As the nation and the world continue to combat the coronavirus pandemic, the AAMC urges Congress and the administration to support efforts to strengthen our public health and health care infrastructure based on preliminary lessons learned from the COVID-19 response, as well as from previous public health and national disaster emergencies, such as measles, Ebola, H1N1, and Hurricanes Katrina and Maria. The AAMC supports the inclusion of at least \$30 billion in the reconciliation package, as proposed in the president's American Jobs Plan, to strengthen the infrastructure that will build the nation's resilience against future pandemics.

Additionally, the AAMC was pleased to submit on June 30 to the [Senate HELP](#) and [House Energy and Commerce Committees](#) an extensive set of recommendations to enhance the country's preparedness and response infrastructure, based on the initial experiences of the academic medicine community throughout the COVID-19 pandemic. AAMC members on the front lines – in research, clinical care, education, and community collaborations – have seen and experienced first-hand the challenges that patients, the public health and health care systems, communities, and the nation continue to face in combatting active COVID-19 infections, addressing long-term symptoms of the disease, and grappling with the inequities heightened by the pandemic. These institutions and health care providers have made critical contributions to the nation's response that complement, and cannot be substituted by, the irreplaceable role that public health officials across the country have played throughout the pandemic.

As outlined in our June 30 letter, in addition to ensuring sustained, reliable investments in public health infrastructure at all levels, such as proposed in Senator Murray's Public Health Infrastructure Saves Lives Act (S. 674), the AAMC recommends:

- Formally engaging the expertise of academic medical centers in pandemic preparedness and response efforts, from strategies to address supply-chain and stockpiling challenges and develop a pandemic planning research agenda, to opportunities to promote data modernization and to prioritize equity in preparedness and response.
- Providing capital funds for teaching hospitals to develop flexible intensive care unit (ICU) capacity through construction of new or renovated spaces outfitted with the necessary components to expand the number of ICU beds in a facility as needed and convert back to general usage when a crisis abates.
- Establishing a competitive grant program to promote greater and stronger collaborations between academic medical centers and their local public health and community organizations.

Academic medical centers have been engaged in nearly every dimension of the nation's response to COVID-19, and as the virus has evolved, so too have their efforts – developing tests and advancing research to combat the novel threat, identifying and delivering clinical care innovations in the midst of surges, launching vaccination campaigns, and leveraging their medical research and clinical care missions in addressing the post-acute sequelae of COVID-19. At the same time, institutions are also struggling to allow their health care and scientific

workforces to heal in the lingering context of a traumatizing crisis that stretched an already lean human infrastructure even thinner – while also addressing the pent-up demands of a population that has delayed care for over a year and working to guard against resurgence of COVID-19 as novel variants pose new challenges. Our nation’s fragmented approach to the pandemic is not sustainable. We urge you to make the necessary investments to strengthen the nation’s preparedness framework.

Research Infrastructure

The nation’s research and development (R&D) enterprise is instrumental in driving innovations that improve people’s health and well-being, catalyzing new industries and economic growth, and building resilience against current and emerging threats. Strengthening and enhancing the infrastructure that underpins this work should be a key national priority.

Medical schools and teaching hospitals are leading centers of medical research, with scientists at these institutions conducting over 50% of extramural research funded by the National Institutes of Health (NIH). This research commitment has enabled AAMC-member institutions to use their capacity to lead research that resulted in successful vaccines and therapeutic candidates, to develop much-needed tests for COVID-19, and to continue to provide the world’s most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. Additionally, federal investments in medical research boost local and regional economies and enhance our national competitiveness. For example, in FY 2020, the federal investment in NIH supported over 536,000 jobs and helped generate \$91.4 billion in economic activity.¹⁰

To continue producing cutting-edge and adaptive medical research discoveries, the AAMC recommends that Congress invest in physical infrastructure to support the U.S. research enterprise and maintain its global competitiveness, recognizing that developing physical infrastructure where such research can take place requires complicated construction that takes many months or years to develop and build. AAMC-member institutions are in nearly every state across the U.S. and conduct a disproportionate share of both basic and medical research to understand the foundational underpinnings of medical science and clinical and translational research that improve the patient care activities provided on their campuses. They often work closely with their partners in the physical, computational, and other sciences to push the boundaries of discovery and improve the human condition. This work requires physical facilities that are well-equipped to advance these goals.

The pandemic has also resulted in major disruptions to the nation’s research enterprise. In addition to delays in research projects across numerous disciplines resulting from lab closures and other safety and distancing measures, the pandemic has taken an especially significant toll on the research workforce, including early-stage investigators, scientists with caregiver responsibilities, researchers from underrepresented backgrounds, and, as highlighted in a recent

¹⁰ <https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf>

report from the National Academies of Sciences, Engineering, and Medicine, on women in science, technology, engineering, mathematics, and medicine.¹¹

The AAMC, along with more than 300 organizations, including the Chamber of Commerce, Google, other higher education associations, patient groups, and others, strongly supports the emergency funding outlined in the Research Investment to Spark the Economy (RISE) Act (H.R. 869/ S. 289). This bill, which has bipartisan support in both the House and Senate, would support approximately \$25 billion in emergency funding for federal research agencies, including \$10 billion for NIH, to mitigate the impact of the pandemic on the research enterprise. To ensure medical research continues to improve the lives of all and to restore the nation's research and innovation capacity, the AAMC strongly urges the inclusion of the RISE Act and one-time supplemental emergency funding for federal research agencies in the reconciliation package.

Health Equity

We appreciate that the budget resolution charts the path for funds to improve health equity, including maternal, behavioral, and racial health equity investments. The COVID-19 pandemic's disproportionate impact on communities of color has laid bare pervasive health inequities, exposing the structures, systems, and policies that create social and economic conditions that lead to health disparities, poor health outcomes, and lower life expectancy. As Congress looks to reduce health disparities facing minority, rural, and other communities, we urge members to include support for programs that will diversify the health workforce, create an equitable standard of data collection, and mitigate the maternal health crisis.

A diverse health workforce contributes to culturally responsive care, helps to mitigate bias, and improves access and quality of care to reduce health disparities. Diversity pathway programs, such as the HRSA Title VII programs, play an important role in improving the diversity of the health workforce and connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities.

Inclusive and diverse education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients and providers. We need to increase investments in these types of programs to enhance the pathway into medicine and other health professions for underrepresented students. The AAMC urges Congress to both develop new innovative initiatives and bolster existing programs that are targeted at diversifying the health workforce.

Race and ethnicity represent only small part of the data collection needed to ensure coronavirus vaccinations are administered equitably. Indeed, neither race nor ethnicity are modifiable risk

¹¹ National Academies of Sciences, Engineering, and Medicine 2021. *Impact of COVID-19 on the Careers of Women in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26061>.

factors. Rather, they are poor proxies for the social risks and social determinants to which communities of color and the residents who live within them are exposed.

Beyond sociodemographic data, we need standardized, valid, inclusive data collection on the social needs and social determinants most likely to correlate with increased exposure, susceptibility, and severity of infectious diseases. Fortunately, those data points are known. The Centers for Disease Control and Prevention (CDC) released a Social Vulnerability Index (SVI) in 2011 and noted that a “number of factors including poverty, lack of access to transportation, and crowded housing may weaken a community’s ability to prevent human suffering and financial loss in a disaster” (CDC 2011). Unfortunately, the SVI have not been incorporated into national COVID-19 response activities to date.

To successfully promote health equity, surveillance system data must:

- Include standardized, core measures that all relevant sectors (health care, public health, social services, etc.) agree to use.
- Allow for data sharing across those sectors while protecting individuals’ information.
- Relate to and complement other crucial data collections (such as using formal ICD-10 Z codes to identify social needs in clinical settings, or vital statistics reporting for public health departments).
- Capture macrolevel data on the social determinants of health geocoded to home addresses when possible, at units of geography that correspond to meaningful, locally defined neighborhoods (i.e., census block, not 5-digit zip code).
- Capture self-reported social needs and vulnerabilities and sociodemographic data including race and ethnicity in ways that allow for the valid, non-stigmatizing collection of potentially sensitive personal information.

The AAMC applauds your efforts to expand coverage for post-partum women, and urges you to take additional action to address inequities in maternal morbidity and mortality. As you are aware, the U.S. has a high rate of maternal deaths when compared to other, similar, countries. While this high rate of death on its own is deeply troubling, the outcomes are even worse for Black, American Indian, and Alaskan Native women. Non-Hispanic black women are three to four times more likely to die from pregnancy-related causes than non-Hispanic white women.¹² Additionally, it is estimated that in the U.S., over 60% of pregnancy related deaths are preventable.¹³ The AAMC applauds congressional action on this issue, including the Senate HELP and House Energy and Commerce Committees for their efforts to address maternal morbidity and mortality. In particular, we were pleased to see the passage of the Maternal Health

¹² Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017.

¹³ Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

Quality Improvement Act (S. 1675/H.R. 4387) in both Committees and urge you to include it in the final reconciliation package.

Immigration

The U.S. health workforce and the patients it serves rely on physicians from other countries, particularly in rural and other underserved communities, and their role is amplified each year as the nation faces growing physician workforce shortages. Additionally, a significant proportion of the U.S. research workforce, including the majority of biomedical postdoctoral researchers, is composed of international scholars.

Physicians from other countries frequently use federal programs such as the State Conrad 30 J-1 Visa Waiver program (“Conrad 30”) and Deferred Action for Childhood Arrivals (DACA) to remain in the U.S. to practice in rural and underserved areas, serving patients of the highest need. The AAMC supports efforts in the reconciliation process to add stability to these programs to help improve access in already underserved communities.

Conrad 30 has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training – more than 15,000 over the last 15 years. Conrad 30 allows physicians to remain in the U.S. in an underserved community after completing medical residency on a J-1 “exchange visitor” visa (the most common visa for GME), which otherwise requires physicians to return to their home country for at least 2 years.

As members consider immigration reform as part of budget reconciliation, the AAMC encourages the inclusion of the bipartisan Conrad State 30 and Physician Access Reauthorization Act (S. 1810/H.R. 3541), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bill for recognizing immigrating physicians as a critical element of our nation’s health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Additionally, we urge you to provide a pathway to citizenship for undocumented young people and those approved for DACA, including the over 27,000 DACA recipients currently in our health workforce. Doing this would ensure that these providers are able to continue their employment, education, training, and research in the health professions.

Health professions students who are undocumented encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in underserved communities. By providing a legal pathway to citizenship DACA recipients, Congress can help our country produce a diverse and culturally responsive health care workforce, able to meet the needs of underserved populations and promote health equity.

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Summary

The AAMC thanks you for your continued leadership and urges you to address these important issues by making critical investments in our nation's health care and research infrastructure. Please feel free to contact me at kfisher@aamc.org to discuss any of these issues as you negotiate provisions of the Build Back Better Act and seek to improve the health of our nation.

Sincerely,

A handwritten signature in black ink that reads "Karen Fisher". The signature is written in a cursive, flowing style.

Karen Fisher, JD
AAMC Chief Public Policy Officer

Cc: House Energy and Commerce Committee Chairman Pallone and Ranking Member
McMorris Rodgers
House Judiciary Committee Chair Nadler and Ranking Member Jordan
House Ways and Means Committee Chairman Neal and Ranking Member Brady
Senate Finance Committee Chairman Wyden and Ranking Member Crapo
Senate Health, Education, Labor and Pensions Chair Murray and Ranking Member Burr
Senate Judiciary Committee Chair Durbin and Ranking Member Grassley