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August 2, 2024

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

The Honorable Larry Bucshon
United States House of Representatives
Washington, DC 20515

Dear Representatives DeGette and Bucshon:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your leadership in support of broadening patient access to life-saving treatments and your recognition of the role of the National Institutes of Health (NIH) and other key federal health agencies in advancing that goal. The AAMC appreciates the opportunity to respond to your June 6, 2024, request for information to inform the next steps in the 21st Century Cures Initiative as you seek to build on the 21st Century Cures Act and Cures 2.0 Act.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, 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, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The AAMC was pleased to support the 21st Century Cures Act and commends the law's effort to sustain investments in medical research across the Department of Health and Human Services (HHS), address administrative burden on researchers, address the role of socioeconomic status in Medicare Hospital Readmissions Reduction Program, and more. In addition, the AAMC appreciated the opportunity to issue feedback on the Cures 2.0 Act. In particular, the AAMC's comments included support for continued investments in research infrastructure; focusing on the implications of long COVID-19; enhancing national testing, vaccine, and response strategies for future pandemics; addressing antimicrobial resistance; improving patient health and digital

literacy; increasing diversity in clinical trials; supporting coverage of clinical trials funded by the Patient-Centered Outcomes Research Institute; including opportunities to equitably increase digital health technology utilization; incorporating real-world evidence in the drug approval process; enhancing communication between the Food and Drug Administration (FDA) and other health agencies; increasing telehealth utilization and extending telehealth flexibilities; providing coverage for innovative technologies and breakthrough devices; addressing access to and coverage of genetic testing and precision medicine interventions; establishment of the Research Policy Board recommended in the 21st Century Cures Act; and increasing federal funding for physician training.

While the 21st Century Cures Act and Cures 2.0 cover a wide range of issues across the health and medical research ecosystem, our comments in response to the RFI focus on guiding principles and recommendations to ensure that the NIH remains the premier organization for conducting and funding medical research, and recommendations to support clinical trial innovation, increase support for the physician workforce, protect Medicare supported teaching health systems and hospitals from harmful cuts, and enhance access to health care.

As you know, the NIH plays a critical role in improving the health and well-being of families and communities through groundbreaking foundational discovery and life-saving medical research conducted by approximately 300,000 researchers at more than 2,500 universities, medical schools, and research institutions in every state in the nation, and serves as an important program of intramural research at the NIH campus. More than half of the external research that NIH supports occurs at AAMC-member institutions pursuing advances in disease prevention, treatment, and diagnosis, across the full spectrum of conditions facing patients everywhere.

In addition to their integral role in advancing discovery, our members provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. In other words, our member academic medical centers not only play a fundamental role in creating the breakthroughs of the future, they also are actively putting such innovations into practice for a diverse array of patients. Their seat at this nexus of research and care delivery gives the experts internally at the AAMC and at our member medical schools, teaching hospitals, and health systems a unique perspective on both the urgency with which patients and their providers seek new and more effective treatments, as well as the challenges and opportunities to accelerate our progress.

We are pleased to submit the following comments, which reflect input from AAMC staff and some preliminary conversations with experts across the AAMC's membership, and build on our previous comments on the "Call to Action" on Cures 2.0 and comments on the Cures 2.0 Act Discussion Draft. Additionally, the AAMC strongly supports the talented leaders and dedicated scientists and staff at NIH and across the HHS who have dedicated their careers to public service. In many cases, the NIH itself has applied its unique expertise and taken initiative in addressing pervasive challenges, often by engaging and with support from the broader stakeholder community.

Accordingly, we have focused many of our comments here regarding NIH on highlighting existing efforts of interest underway, clarifying the purpose of current policies and practices, and/or suggesting areas where we believe Congress, as opposed to NIH itself, is best positioned to take action to strengthen the research enterprise.

Many of our suggestions here also align with the input we provided in response to Senator Cassidy's fall 2023 request and that we will be submitting in response to Chair Cathy McMorris Rodgers' recent request. We welcome the opportunity to continue to serve as a resource to you and your staff as you undertake this process and to elaborate further on the initial feedback in this letter.

Do the policies included in Cures 2.0 that have advanced through legislation or executive action meet the needs that the original Cures 2.0 bill aimed to address?

Research Policy Board

The AAMC understands the critical responsibility that NIH has in its stewardship of the federal funds it has been tasked with allocating, and history has shown that the agency takes this responsibility seriously. Among other examples, its actions to address the challenges of research security head on and its continuous improvement of internal oversight procedures have demonstrated this commitment. We also understand that Congress in its oversight function plays a role along with the NIH in ensuring wise stewardship of federal resources. The AAMC has long supported the development of a research policy board to look at oversight and regulatory burden across agencies. This board, comprised of expert federal and non-federal members, was a key component of the 21st Century Cures Act and Cures 2.0 Act and was enthusiastically supported by the biomedical research community as a way 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."[1]

Unfortunately, despite the statutory requirement for the implementation of the board, to date the research policy board has not been created. The AAMC continues to see this board, which intentionally included membership from across the biomedical research community, as a powerful tool in transparency and in reducing regulatory burden. We encourage activities that would facilitate the creation and implementation of the board.

21st Century Cures Innovation Account

[1] "21st Century Cures Act, H.R. 34, 114th Cong., Pub. L. No. 114-255, 130 Stat. 1033 (2016). Retrieved from https://www.congress.gov/bill/114th-congress/house-bill/34/text

The 21st Century Cures Act established the Innovation Account to provide multiyear support for specific initiatives at the NIH and other federal health agencies. The AAMC is immensely grateful for the resources that the Innovation Account provided, which, coupled with above-inflation appropriations increases, have allowed NIH to support specific-large scale initiatives, such as the Cancer Moonshot, without forcing the agency to redirect resources from other existing and emerging fields of study. Sustainable, predictable funding growth for medical research and all federal agencies that support the public health continuum is key in ensuring that our nation can fully benefit from the wide range of scientific advances and build on developing knowledge to improve health over the long term.

As you move forward to craft the next-generation Cures bill, we note opportunities to enhance the impact of the Innovation Account even further. While the Innovation Account provided greater predictability in funding for the specific initiatives it supported, the dramatic fluctuations in year-to-year resources limited the ways the funding could be used, and its time-limited nature established a cliff upon the Account's expiration. Developing a steadier trajectory for the Account and providing permanent funding could enhance its utility even further. Moreover, to help expand the Account's benefits to the full scope of research supported by NIH, there may be other mechanisms, some of which are already in practice at other agencies, worth exploring that would strengthen funding stability; for example, it may be helpful to explore: the feasibility of no-year funding, as appropriate; advanced appropriations; and/or creation of a new budget category that would exempt key health agencies like NIH from annual discretionary spending limits. Recognizing that many of these ideas span the jurisdiction of multiple Congressional committees, we work forward to working with lawmakers across Congress to optimize the Innovation Account's future functionality and to avoid any unintended consequences of targeted funding.

Structural Actions

The structure of the NIH has provided grantee institutions and researchers with a predictable framework for aligning funding priorities with developing basic biological understanding as well as disease-specific fields of inquiry. In addition to novel grant mechanisms that can support individual investigators, multidisciplinary projects, or areas of specific need, the addition of the Advanced Research Projects Agency for Health (ARPA-H) to the tools available to fund research provides an encouraging new mechanism for advancing high-risk, high-reward research.

Success in biomedical research requires a wide variety of approaches and perspectives, and the addition of the ARPA model to an already robust federal biomedical research enterprise presents exciting potential. We have long held that ARPA-H should complement, and not replace, the research portfolio that NIH currently conducts, and that funding for ARPA-H should be supplemental to the budget for NIH. We also support the continuation of NIH's own high risk, high- reward research program, managed under the Common Fund within the Office of the Director, comprised of four awards that are innovative in focus, review, and structure, and subject to a comprehensive evaluation process. While ARPA-H is promising, it is still in the very

early stages of its research agenda and should be allowed to progress and be evaluated prior to making any assumptions or major changes to its structure.

While we believe that the current structure of NIH has been extraordinarily successful and continues to serve as the world's leading public funder of medical research, we also recognize the value of periodically assessing opportunities for greater efficiency. To the extent that Congress opts to pursue such a review, we strongly urge that it be driven by scientific need and rationale and informed through a deliberative process that is informed by stakeholders, the agency, and other experts and is appropriately and carefully implemented to minimize disruption across the medical research enterprise.

Extending Access to Telehealth Services & Innovative Care Modalities

Congress and the Centers for Medicare and Medicaid Services (CMS) have expanded patient access to telehealth services since the start of the COVID-19 pandemic. Currently, flexibilities to waive the statutory geographic restrictions for accessing telehealth are set to expire on December 31, 2024. We strongly urge Congress to pass the Telehealth Modernization Act of 2024 (H.R. 7623), which would extend these key telehealth flexibilities and maintain patient access to modern, innovative health care delivery modalities that support timely and effective care.

The AAMC strongly supports efforts to incentivize the use of interprofessional internet consults. Payment for these services can improve quality and efficiency, improve timely access to specialty input, and enhance the patient's experience through more effective communication and coordination between providers. While the AAMC recognizes there are typically limited scenarios where coinsurance is waived in the Medicare program, we continue to believe that requiring coinsurance for these consults will stifle the use of these value-promoting, physician-to-physician services. Therefore, Congress should explore waiving the patient coinsurance for these services. At a minimum, we believe the coinsurance should be waived in circumstances where there is a straightforward mechanism to do so, such as CMMI's ability to do so for specific services in Alternative Payment Models (APMs).

What elements might be missing that are essential for further progress?

Supporting the Next-Generation of Medical Researchers

Our nation must invest in predictable funding for medical research to continue our progress in advancing health and also to bolster our research workforce. The unpredictability of funds discourages individuals, especially early-stage investigators, from pursuing academic research careers, as the lack of predictable funding may hamper the ability to sustain their research programs. There have been various proposals to counter these troubling trends. One model that has demonstrated some promise is the NIH Maximizing Investigators Research Award (MIRA), which provides investigators with more stable funding as the grants are generally longer and more flexible than other research grants. We believe this model could be one, among others, that

Congress could explore; by facilitating the use and NIH's evaluation of such models as a complement to existing funding mechanisms, Congress can help support NIH's work to reduce year to year uncertainty on any particular grant and identify evidence-based approaches to address some of the most pervasive and pressing challenges facing the science workforce.

Another area of interest that observers have identified is in expanding the reach of NIH's resources to an even greater diversity of awardees. While we would like to emphasize the critical and necessary role of NIH's peer review process in identifying the most promising science to fund, we also recognize the opportunity for support across a wider range of potential grantees demographically, geographically, and institutionally. The NIH's Institutional Development Award (IDeA) program provides funding for centers and for research networks within qualified states. As with other NIH research, the IDeA program relies on rigorous peer review to determine excellence among competing programs. As such, the program has demonstrated that the NIH is able to help build research capacity within regions that traditionally have not been recognized as significant venues for medical research, and that more communities and institutions have potential to participate in and directly contribute to biomedical discovery and application. Exploring the feasibility of applying such a model to other areas of underinvestment could help reveal additional opportunities to broaden participation in NIH research, particularly if implemented as a supplement to existing programs rather than at the expense of current investments.

The AAMC is very aware that the future of biomedical research depends on the successful development, retention, and support of research trainees and early career scientists. The AAMC appreciates the focus that NIH has placed on supporting scientists early in their careers and notes that NIH is limited in certain efforts as a result of the agency's authority, funding, or regulations from other agencies.

Additionally, the AAMC appreciates the work of the NIH in implementing an agency-wide strategic plan for diversity, equity, inclusion, and accessibility (DEIA) in alignment with complementary initiatives, including the UNITE initiative to address structural racism and the strategic plan by the Chief Officer for Scientific Workforce Diversity to bolster inclusive excellence in the biomedical workforce. The AAMC also commends the NIH for establishing the Maximizing Opportunities for Scientific and Academic Independent Careers (MOSAIC) program, for which AAMC is a grantee, and the Faculty Institutional Recruitment for Sustainable Transformation (FIRST) program. These programs are working to build cohorts to support researchers in a successful transition to research faculty positions.

Supporting Clinical Trial Innovation

The AAMC believes that clinical trials will be most effective in improving the health of the nation's families and communities if they intentionally include diverse populations. Ensuring that clinical trial participants represent a wide variety of socioeconomic and geographic communities helps researchers understand the efficacy of treatments among different populations in different

contexts. We know that lower income participants who participate in clinical trials may experience financial burdens, a factor which represents a significant barrier to recruiting diverse cohorts. When researchers increase financial incentives for participation in clinical trials, they are more likely to successfully recruit a more representative sample of participants, which will ultimately increase the generalizability of the research. However, under current law the compensation that participants receive is considered taxable income.

The AAMC supports the Harley Jacobson Clinical Trial Participant Income Exemptions Act (H.R. 7418), which would amend the Internal Revenue Code to exclude compensation received by an individual for participating in an approved clinical trial from taxable income. Exempting compensation received for clinical trial participation from taxable income can incentivize participation from low-income communities, who are underrepresented in clinical research, particularly those who have limited disposable income, family-care obligations, and inflexible work schedules. The provisions of the proposed legislation represent a meaningful improvement to support populations who experience additional financial burdens to clinical trial participation.

Increasing Support for the Physician Workforce

In addition to the specific focus areas referenced in your call for input, it also is critical to recognize that demand for physicians continues to grow faster than supply, posing a significant challenge for patients in accessing care and new discoveries. Physicians are a critical element of our national health care infrastructure and workforce, and if we do not address this shortage, patients from all communities will find it difficult to access the care they need. The AAMC projects a shortage of up to 86,000 physicians by 2036.[2] Moreover, in a separate analysis from the shortage projections, the AAMC found that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need up to 202,800 more physicians than it has just to meet *current* demand. This illustrates the magnitude of barriers to care and provides an additional reference point when gauging the inadequacy of physician workforce supply.

Congress should build on its historic and bipartisan investment in Medicare support for graduate medical education (GME) included in the Consolidated Appropriations Act, 2021 (P.L. 116-260) and Consolidated Appropriations Act, 2023 (P.L. 117-238), to help ensure access to care for patients and communities. Specifically, the AAMC strongly supports the Resident Physician Shortage Reduction Act of 2023 (H.R. 2389), bipartisan legislation introduced by Reps. Terri Sewell and Brian Fitzpatrick, that would provide 14,000 Medicare-supported GME positions, enabling teaching hospitals to train more physicians. We urge Congress to pass this important legislation in order to help meet the needs of communities struggling with patient access to care.

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[2] Association of American Medical Colleges. (2023). *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*. Association of American Medical Colleges. https://www.aamc.org/media/75236/download?attachment

Addressing Structural Challenges with the Medicare Physician Payment System

As currently structured, the Medicare physician payment system is on a path that jeopardizes Medicare patients' access to physicians. The Medicare Access and CHIP Reauthorization of 2015 (MACRA) established a six-year freeze on updates to physician payments from 2019 through 2025; in other words, during this period there would be no updates to Medicare payments to physicians. Beginning in 2026, the law specifies that clinicians participating in advanced alternative payment models (APMs) who also meet certain thresholds would receive an update of 0.75 percent, and those who are not in advanced APMs would receive a 0.25 percent update. These updates are well below the rate of inflation. According to an American Medical Association (AMA) analysis of Medicare Trustees' data, when adjusted for inflation, Medicare physician payment has been reduced by 26 percent from 2001–2023. In addition to reductions in reimbursement, in recent years physicians have faced numerous challenges, including the COVID-19 pandemic and its aftermath, rising inflation, and workforce shortages.

Looking ahead, the AAMC believes that there are ongoing structural problems with the Medicare PFS that must be addressed by Congress. Medicare provider payments have been constrained for many years by the budget neutrality system. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. The budget neutrality requirement has led to arbitrary reductions in reimbursement. The AAMC believes that any payment system provides financial stability through a baseline positive annual update that reflects inflation in practice costs and eliminates or replaces budget neutrality requirements to allow for appropriate changes in spending growth. The payment system should also recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations that would increase Part A costs).

The AAMC thanks Dr. Bucshon for his efforts to ameliorate many of these concerns, and we strongly support the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would make key improvements to the PFS, including tying updates to the full Medicare Economic Index (MEI) beginning in 2024.

Strengthen Incentives for Value-based Patient Care

Value-based care is improving patient care and successfully reducing costs in the health care system. These payment system reforms have been a good investment for the government. For example, accountable care organizations (ACOs) participating in the Shared Savings Program have saved Medicare $13.3 billion in gross savings since 2012 and, according to an HHS Inspector General Study, ACO clinicians have outperformed FFS providers on 81 percent of quality measures. APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

Under advanced APMs, participating clinicians bear financial risk for the cost and quality of care. The bonus payments have been critical to clinicians in covering the investment costs of

moving to new payment models and reinvesting the 5 percent bonus payment into practice redesign to better manage care. This includes investing in new electronic health records (EHRs), additional staff, telehealth managers, telehealth platforms, and other areas that will enable them to better manage care when they bear the financial risk. For example, ACOs have used these incentives to fund wellness programs, pay for patient transportation and meals programs, and hire care coordinators. Although these services are not typically reimbursed under the Medicare program, they have been shown to improve health outcomes.

The AAMC is concerned that the lack of the financial incentive under the Quality Payment Program for APMs for the CY 2027 payment will discourage participation in advanced APMs in performance year 2025 and subsequent years. While there will be a higher update to the conversion factor beginning in 2026 payment year for qualifying participants (QPs) in an advanced APM as compared to non-QPs, we do not believe that this higher update will be sufficient to incentivize participation. Therefore, we urge Congress to pass the Value in Health Care Act (H.R. 5013), which would extend the advanced APM 5 percent bonus for an additional 6 years.

Relatedly, we remain deeply concerned about the increase to the QP thresholds that will occur for CY 2027 payment year (2025 performance year). The increasing thresholds that must be met to be considered QPs in an advanced APM will discourage participation, thereby limiting beneficiary access to high quality and better coordinated care. It is very difficult for APMs to increase the volume of payments received through the APM or the number of Medicare FFS patients who receive services through the APM. It is especially difficult for ACOs in rural areas and those that include specialists since primary care services are used to determine ACO assignment. We urge Congress to give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models.

What additional reforms, support mechanisms, or incentives are needed to enhance or improve the effectiveness of the steps already taken, including any structural reform to agencies, offices, or programs involved?

Aligning Structural Changes with Science

As noted above, as it is currently organized, NIH has been extraordinarily successful and continues to serve as the world's leading public funder of medical research. At the same time, as our understanding and methods for science and medicine continue to evolve, we acknowledge the value of ensuring that the agency's composition remains nimble and aligned with opportunities for the greatest scientific and functional efficiencies. To the extent Congress chooses to pursue any realignment of the structure or organization of NIH, we urge that it should be through a process that engages the relevant experts from both the community and the federal government. Likewise, for any new programs Congress may choose to establish, we recommend an approach that starts with pilot projects and/or that empowers NIH to implement any potential changes through a phased process that allows collaboration with, deliberation among, and feedback from medical research stakeholders. Ensuring that any changes are informed by the necessary engagement and implemented in a stepwise, evaluative manner will have a greater

chance of success than dramatic and/or arbitrary changes that risk upending the medical research enterprise. These principles will be important safeguards to ensure the U.S. continues to lead the world in medical research and does not jeopardize our potential to pursue cures, drive innovation, and maximize the economic returns from federal investment in scientific research.

Supporting Academic-Industry Partnerships

Supporting academic-industry collaborations is critical to translating basic research discoveries into diagnostics, treatments, and cures for patients. Efforts to promote academic-industry collaborations should recognize that the 1980 Bayh-Dole Act has been exceptionally successful in incentivizing private investment in university-based inventions from federally sponsored research. Further, the Act helped catalyze the development of a community of academic tech transfer and licensing professionals. The Bayh-Dole Act included safeguards, such as march-in rights, to protect public interests in unusual or unforeseen situations. The AAMC does not believe that exercising march-in rights would be an effective way of addressing systemic concerns, such as around the affordability of pharmaceuticals, and that such problems should be addressed through other measures, not Bayh-Dole.

Avoid Policies That Undermine Academic Medicine

The AAMC urges Congress to avoid counterproductive policies that would cut Medicare support to teaching health systems and hospitals, including misguided cuts to hospital outpatient departments (HOPDs). It is undeniable that 2023 was a difficult year for our nation's teaching health systems and hospitals, which faced profound financial challenges stemming from historic workforce shortages, unprecedented growth in costs, and significant uncertainty as states resumed Medicaid redeterminations. According to MedPAC, hospitals' overall FFS Medicare margins dropped to a record low 11.6 percent in 2022, and this trend is expected to persist in the coming years.

These so-called "site-neutral" payment policies have recently been proposed as a savings mechanism or offsets for legislation. The policies are inherently counterproductive in that they would only further exacerbate financial challenges by cutting Medicare reimbursement for care delivered in HOPDs. The AAMC strenuously opposes these policies, which disregard the real differences between teaching health systems and hospitals' HOPDs and other sites of care, including physician offices and ambulatory surgical centers. As we have emphasized to policymakers, teaching health systems and hospitals' HOPDs care for a more clinically and socially complex patient population than physician offices, while complying with greater licensing, accreditation, and regulatory requirements. Because of these factors, the cost of providing care in an HOPD is fundamentally different from other settings. Enacting HOPD policies ignores these important distinctions and would result in cuts to Medicare reimbursement for services in off-campus HOPDs. Proposed HOPD cuts, and in particular, those passed by the House of Representatives in the Lower Costs, More Transparency Act (H.R. 5378), target AAMC member teaching health systems and hospitals, many of which are safety-net providers

that care for the nation's sickest and under-resourced patients, including in the outpatient setting. Although our members comprise just 5 percent of all U.S. hospitals, they would shoulder nearly half of the cuts included under the House-passed policy. Given teaching health systems and hospitals' critical role in caring for Medicare's most vulnerable and complex beneficiaries, these proposed cuts would limit these patients' access to life-saving care and cutting-edge treatments. The negative impacts of these cuts would be felt most acutely in rural and other medically underserved communities.

Although significant investments are needed to sustain and enhance investments in medical research and ensure patient access to care, the AAMC opposes financing these provisions through cuts in the Medicare program. As noted above, AAMC-member teaching health systems and hospitals educate and train the nation's workforce and conduct the research that develops new cures and therapies. They cannot absorb additional cuts, as it would be impossible to continue their missions of patient care, education, research, and community collaborations. We implore you to reject counterproductive HOPD cuts and avoid the seriously detrimental effect on teaching health systems and hospitals and avert endangering access to care for the patients and communities they serve.

Ensuring Sustained, Predictable Growth in Medical Research Support

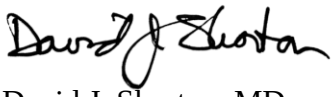
Additionally, while the AAMC supports exploring the potential of NIH structural changes in enhancing efficiencies, we caution any such improvements will be limited without the appropriate funding support. Without question, the bipartisan, decades-long federal commitment to NIH and the U.S.'s global leadership in medical research have been instrumental in advancing science to combat nearly every health threat facing patients nationwide. Even in the midst of the extraordinary investment Congress has made in NIH over the last decade, however, scientific opportunity continues to far outpace available resources. NIH currently only is able to support 1 in every 5 promising funding proposals, with some institutes forced to turn away even a far greater share of applications. Moreover, recent appropriations have been key in assisting the agency to recover lost purchasing power after a decade and a half of flat or effectively flat funding, but still have not reached, in inflation-adjusted terms, our 2003 level of investment. "Boom and bust" cycles of funding, particularly when coupled with flat or decreased funding and delayed completion of the annual appropriations process, are counterproductive, particularly given the long-term nature of discovery.

To fully optimize the nation's potential to advance new preventive interventions, diagnostics, therapeutics, and cures – and to lay the groundwork for the scientific "miracles" that will protect us against emerging threats and bolster our national security – it will be essential to ensure the nation sustains a commitment to predictable, robust growth for the NIH over the long term. We cannot afford to underinvest in medical research or to stifle lines of inquiry by drawing artificial boundaries on science. We hope to work with lawmakers to resume a trajectory of sustained, robust growth for NIH in FY 2025 and beyond, with as much stability and predictability of funding as possible.

Conclusion

Thank you again for the opportunity to provide feedback on this timely RFI. The AAMC and its members take seriously the responsibility entrusted in awardees to ensure that medical research funds advance our understanding of medicine and health, leading to improved health outcomes for the patients our members serve. As mentioned above, my colleagues and I hope to continue to serve as a resource to you and your team and look forward to continuing to discuss our mutual goal of improving the health of all. Please contact AAMC Chief Public Policy Officer Danielle Turnipseed, JD, MHSA, MPP (dturnipseed@aamc.org) or Senior Director of Public Policy & Strategic Outreach Tannaz Rasouli (trasouli@aamc.org) with any additional questions.

Sincerely,



David J. Skorton, MD
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