Tom Frieden, M.D., M.P.H., President and CEO, Resolve to Save Lives, Former Director, Centers for Disease Control and Prevention

The Honorable Frank Pallone, Jr. (D-NJ)

1. Dr. Frieden, thank you for your work and dedication to national and global health. I would like to discuss another incredibly important provision within the public health infrastructure title of this bill.

Section 4005 provides $5 billion for infrastructure improvements at facilities funded by the Indian Health Service (IHS), which provides care to over 2 million American Indians and Alaska Natives across the country. It is important to note that Congress works in tandem with IHS and consults with tribal governments to establish a sound budget and identify culturally competent best practices.

The past year has been incredibly challenging for tribal communities. They've experienced some of the worst per capita infection rates and many areas lack accessible care. Apart from our statutory responsibility, it is our moral obligation to work with IHS and tribal governments to improve health care for Native Americans. Our investment in IHS infrastructure will go a long way toward achieving those goals.

1. Why is it important to modernize IHS facilities and how can we incorporate tribal health into broader public health?

   As you know, the U.S. government has legal trust responsibility to uphold the treaty responsibility for health care of Tribes, including through the Indian Health Service (IHS). As you also know, the health status of many tribal populations is precarious, with a much higher rate of many health problems, such as diabetes, and therefore a higher need for health and mental health services. Many IHS facilities have been long overdue for upgrading physical spaces and medical technology. This would improve patient care and increase facility patient capacity. These IHS health systems can be incorporated into the broader public health and health care system through focused programs, including cooperative grants to help state and local health jurisdictions work more collaboratively with IHS, Tribal and Urban Indian Health Organizations. Additionally, there is a need to inform the broader public health community about American Indian and Alaska Native (AI/AN) culture and history. "Public health practitioners and policy makers are often unaware of important concepts such as federal Indian law, trust responsibility, sovereignty, self-determination, consultation requirements, and research abuses. Many data challenges limit the quality of information available about the American Indian/Alaska Native population, resulting in under-reporting and misrepresentation of the public health conditions affecting the population." (*Priorities in Tribal Public Health* APHA, TPEH). We must additionally strengthen cooperative case investigation and reporting through improved public health laws, MOAs/MOUs and data sharing agreements that recognize tribes as sovereign nations with public health authority for their people.

Having full-time tribal liaisons within local and state health departments could bridge some of the gap between these jurisdictions. Some state health departments such as the Oregon Health Authority and Utah Department of health have adopted this model where a representative of IHS or designated tribal liaison has an office at the state health department.

2. Urban Indian Organizations play a critical role in increasing access to health care for native populations. Health IT infrastructure is critical to identifying and monitoring these patients. How can we better identify gaps in data and needs for new data collection?

   Throughout the COVID-19 pandemic, the gaps in public health data collection and sharing were glaring across the entire country, especially in communities greater social vulnerability such as tribal populations. The need to upgrade, increase information security, and make health IT systems interoperable is clearer than ever.

   Policy makers and public health professionals can identify gaps by evaluating existing health IT systems, asking the key users (health care staff, health care laboratory staff, public health, first responders) what they found were the biggest gaps and needs. However, one challenge with this approach is that system users may not be aware of what enhancements would be most valuable. Previous efforts to identify these gaps have found that areas to prioritize are:

   - Reviewing and modifying existing Federal policies and regulations that present barriers to information exchange (e.g. the Privacy Act and Part 2 additions, HIPAA, etc.) by developing standards that both safeguard protected health information and facilitate the sharing of that information between jurisdictions following the same standards.
   - Improving the exchange of information between Tribal programs and IHS, and between IHS, Tribal and Urban programs in States and local health jurisdictions.
   - Expanded funding and incentives for Tribes to adopt new, certified Electronic Health Record (EHR) systems
   - Continued support for IHS Health IT modernization efforts.

3. How does tribal health infrastructure fit into national health security?

   Diseases know no borders. Preventing the spread of an infectious disease on Tribal lands is critical to the containment of any disease with pandemic or epidemic potential. Providing enhanced infectious disease detection and reporting capabilities to IHS and Tribal facilities can increase the representation of this information from predominantly rural areas.

   IHS, Tribal and Urban programs have been recognized for their success in the COVID vaccination program. AI/AN have the highest per capita uptake of these vaccines

compared to other races/ethnicities. Other health systems can learn from those successes for future rural vaccine distribution efforts.

National health security is a collective responsibility among Federal, State, Tribal, Local, and Territorial governments and public private partners and members of the community to enable a whole-of -government, whole-of-nation approach, as outlined in the 2019-2022 National Health Security Strategy, US Department of HHS. Tribal nations are integral to meet the 3 objectives in the Strategy:

- **Prepare, mobilize, and coordinate the Whole-of-Government to bring the full spectrum of federal medical and public health capabilities to support State, Local, Tribal, Territorial, (SLTT) authorities in the event of a public health emergency, disaster, or attack.**

- **Protect the nation from the health effects of emerging and pandemic infectious diseases and chemical, biological, radiological, and nuclear (CBRN) threats.** From an infectious disease perspective, Tribal health infrastructure can help identify new infectious diseases in less urban areas that could spread to urban areas. Example: Tribal health infrastructure and IHS were crucial in identifying a new pathogen (hantavirus) as the cause of deaths in the Four Corners Area in 1993. (CDC). Interestingly, "The Navajo Indians, a number of whom contracted HPS [hantavirus pulmonary syndrome] during the 1993 outbreak, recognize a similar disease in their medical traditions, and associate its occurrence with mice."(CDC)

- **Leverage the capabilities of the private sectors**
    1. For fostering creation of resilient medical supply chain:

       Some tribes were able to choose where to get medical supplies for COVID-19 including testing kits, PPE, and vaccines through the US government and also private sectors either directly or indirectly (through state health department partnerships). For example, one tribe partnered with the state health department's emergency operations center for COVID-19 to get on the list to order PPE from a private company who is working with the state. And, concurrently the tribe can access the Strategic National Stockpile for similar supplies.

    2. For sustaining and improving private sector health care surge capacity for large-scale incidents:

       In addition to US Public Health Service/IHS health care professionals, some tribes could use the National Guard and people from the Medical Reserve Corps. Other options may include utilizing traveling nurses, locum tenens services and NGO's.

Thank you, Dr. Frieden. I want to reiterate that the health of our tribal communities is an indicator of our solvency as an advanced country and economy. The pandemic has disproportionately affected our most vulnerable communities, which were already living with pre-existing health inequality. Our return to normalcy must not leave anyone behind. I hope my colleagues will join me in that commitment.

The Honorable Michael C. Burgess (R-TX)

1. Initially established in the 1940s, Hill-Burton gave hospitals and other health facilities construction money in exchange for those providers offering a reasonable volume uncompensated and charity care to patients unable to pay. Things have changed a lot since the 1940s. For example, in order to maintain their tax-free status, non-profit hospitals must provide care for those without insurance or the means to pay. In addition, the Emergency Medical Treatment and Labor Act, or EMTALA, requires anyone coming to an emergency department to be stabilized and treated, regardless of insurance status or ability to pay. Disproportionate Share Hospital, or DSH, payments provide additional funding to hospitals that serve a disproportionate number of low-income patients. On top of that, in order to receive 340B drug discounts, a hospital must have a sufficient Medicare DSH adjustment percentage. In the outpatient space, community health centers are required to primarily treat those with limited ability to pay.

a. That said, given the many incentives already in place, how would Hill-Burton infrastructure payments increase the provision of uncompensated care?

Thank you for that question. As you know, hundreds of rural hospitals have struggled and as of 2020, 136 of these rural hospitals closed since 2010. Of the states that have seen at least one rural hospital close over the past decade, Texas led with 21 rural hospital closures.

Rural and urban hospitals care for communities and populations often with the greatest health and socioeconomic needs. They care for underrepresented people and are a health care anchor for communities across the country. They reach outside their walls to care for communities where more than 23 million people live below the federal poverty line, nearly 10 million have limited access to nutritious food, and 360,000 experience homelessness. However, those walls and basic medical infrastructure are crumbling. An article last spring detailed the experience of one hospital in New York City, SUNY Downstate, at the onset of the COVID-19 pandemic. It served a community that sees high numbers of low-income patients and patients of color and accommodates more than three times the number of patient visits than it was built to handle nearly 60 years ago. During the height of the COVID-19 crisis in New York State last spring, which disproportionately harmed populations served by the hospital, clinicians cared for patients with handmade workarounds, such as “plastic tarps and duct tape” to separate patients. The article reported that a “leaky roof forced a temporary evacuation of

premature babies from a neonatal intensive care unit" and that the "bunkerlike concrete building is crumbling from within."

Additionally, physical infrastructure investments should be paired with digital investment in upgrading EMR systems and enabling safety net providers to leverage telehealth capabilities to reach beyond their walls and into the communities where their patients live and work.

- **The Honorable Robert Latta (R-OH)**

1. The CARES Act provided $500 million in discretionary appropriations to modernize the public health infrastructure in the United States. To that end, Congress has passed hundreds of millions of dollars due to the COVID-19 pandemic to address the needs of our health providers during this crisis. It is Congress's responsibility to assess total costs and timelines in order to review appropriate actions. Do you believe that moving forward without this information is irresponsible of Congress and hurtful to the American taxpayer?
2. For example, one section of this bill provides $1 billion to the CDC to expand and improve public health infrastructure and activities. Why is this funding needed when the CARES Act provided $500 million in discretionary appropriations for public health data surveillance and analytics infrastructure modernization and the American Rescue Plan provided $500 million in mandatory appropriations for these same functions? CBO projected that only one fifth of that money would be spent over the next 7 months.

   I believe we are spending money we don't have to address problems that have already received funding.

   As you know, our U.S public health infrastructure was underfunded for decades at the federal, state, and local levels. As a result, our nation was woefully underprepared for this devastating pandemic. More than 56,000 public health workforce jobs at the state and local levels were cut between 2010 and 2020.[1] In the United States, per capita spending on public health is less than 3% of total health care expenditures, and if the pandemic has taught us anything it should be that preventing the spread of infectious disease both domestically and globally is a national security and economic imperative.

   The emergency appropriations divided over several supplemental bills to respond to the COVID-19 pandemic were critically necessary to save lives and stabilize our economy. However, these supplemental appropriations were not long-term investments. They were more like plugging a sinking boat with a very expensive plug. Had our nation made the decision to invest in public health and preparedness prior to the pandemic we could have saved trillions in economic recovery costs, and billions in public health response costs.

[1] https://www.tfah.org/report-details/publichealthfunding2020/

As you indicated in your question, our public health data infrastructure was one area where public health was decades behind. At the start of the pandemic, it was common for test results to be delayed because labs would have to use fax machines to send results between providers and health departments. Additionally, data sent from health departments to HHS would lack basic information such as sex, age, race, etc. The initial funding provided by Congress for modernizing our public health data infrastructure in the CARES Act was another example of where the emergency appropriations were only playing catchup with a down payment after years of underinvestment. These funds must be sustained, and I support the goals of the LIFT Act to provide CDC with flexible sustainable resources to cover underfunded areas including workforce capacity, health information, disease surveillance, and other critical core public health needs.

To your question of oversight, when I was CDC Director, I took the first line of the agency's pledge to the American people very seriously: "Be a diligent steward of the funds entrusted to our agency."[2] I agree with you that Congress has the power of the purse and should conduct all appropriate oversight of the funds appropriated to CDC and all other associated COVID-response agencies. However, I believe that Congress can both conduct oversight and make investments to prevent the next pandemic now by finally making sufficient sustainable investments in our nation's public health infrastructure to ensure the taxpayers never again have to suffer through a pandemic that costs hundreds of thousands of lives and trillions of dollars. As Rep. Tom Cole said, "it is a no brainer to spend billions to save trillions."[3]

- **The Honorable Earl L. "Buddy" Carter (R-GA)**

1. Dr. Frieden, there is a growing recognition that part of the public health response includes social determinants of health, including non-emergency medical transportation (NEMT) to health services such as vaccine sites at community pharmacies. While Medicaid beneficiaries have access to a non-emergency medical transportation (NEMT) benefit, Medicare beneficiaries do not. I have introduced a bipartisan bill, H.R. 2080, that would authorize a temporary Medicare benefit to get beneficiaries to and from vaccination sites. Do you agree on the importance of transportation to vaccine sites if we are to get all of our Medicare beneficiaries vaccinated against COVID-19?

Thank you for this question. As you indicated, there is extensive research that concludes addressing social determinants of health is important for improving health outcomes and reducing health disparities. The COVID-19 pandemic exacerbated already existing health disparities for a broad range of populations, but specifically for people of color. The legislation you have proposed could have positive effects in closing some of those gaps by ensuring all seniors have affordable access to and from COVID-19 vaccination

[2] https://www.cdc.gov/about/organization/pledge.html
[3] https://thehill.com/policy/finance/496369-key-lawmakers-eye-off-budget-account-for-pandemic-speding

sites, especially those with limited mobility and in rural areas. Reducing barriers to vaccination, including the cost and convenience of transportation, is a proven and important way of improving vaccination uptake. Ensuring the most vulnerable members of our population are all vaccinated should be our highest priority and I commend you on this bipartisan legislation that could bring us a step closer to that goal.