

EMPOWERED BY DATA: LEGISLATION TO ADVANCE EQUITY AND PUBLIC HEALTH

HYBRID HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTEENTH CONGRESS FIRST SESSION

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¹The legislation has been retained in committee files and is available at <https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=112817>.

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THURSDAY, JUNE 24, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, and remotely via Cisco Webex online video conferencing, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Matsui, Castor, Sarbanes, Welch, Schrader, Cárdenas, Ruiz, Dingell, Kuster, Kelly, Barragán, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio), Guthrie (subcommittee ranking member), Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Staff present: Shana Beavin, Professional Staff Member; Jeffrey C. Carroll, Staff Director; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Clerk; Zach Kahan, Deputy Director, Outreach and Member Service; Una Lee, Chief Health Counsel; Meghan Mullon, Policy Analyst; Joe Orlando, Policy Analyst; Michael Ovin, Health Fellow; Tim Robinson, Chief Counsel; Chloe Rodriguez, Clerk; Kylea Rogers, Staff Assistant; Andrew Souvall, Director of Communications, Outreach, and Member Services; Kimberlee Trzeciak, Chief Health Advisor; Alec Aramanda, Minority Professional Staff Member, Health; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Seth Gold, Minority Professional Staff Member, Health; Grace Graham, Minority Chief Counsel, Health; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, Oversight and Investigations Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Olivia Shields, Minority Communications Director; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

Ms. ESHOO. The Subcommittee on Health will now come to order. And due to COVID-19, today's hearing is being held both remotely and in person.

For Members and witnesses taking part remotely, microphones will be set on mute to eliminate background noise. Members and

witnesses, you will need to unmute your microphone when you wish to speak.

Since Members are participating from different locations at today's hearing, recognition of Members for questions will be in the order of subcommittee seniority. So keep that in mind.

The documents for the record should be sent to Meghan Mullen at the email address that has been provided to your staff. All documents will be entered into the record at the conclusion of the hearing.

The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

"Underfunded and under threat." That was the Associated Press and Kaiser Health News' indictment of the U.S. public health system, based on their award-winning investigation last year. The investigation found that, since 2010, spending for State public health departments dropped by 16 percent per capita, and spending for local health departments fell by 18 percent. At least 38,000 State and local public health jobs have disappeared since the 2008 recession.

Our hollowed-out public health system explains why we have seen COVID-19 cases tracked using fax machines and COVID-19 vaccines recorded on little white paper cards. These antiquated methods are embarrassing for our country that once held a—had a globally respected public health system. And our disarrayed data collection has brought our—consequences for so many Americans. It has allowed racial health disparities to flourish without intervention. And as the common maxim goes, you can't manage what you can't measure.

The 13 bills our subcommittee is considering today begin to rebuild our public health systems beyond pen-and-paper data collection and inconsistent definitions. Several of the bills use data to help our health systems improve the overall health and wellness of local populations rather than treat individual sickness.

I am proud to colead, with Representative Peters, the Health STATISTICS Act, which directs the CDC to develop uniform, public health data standards for State and local health departments.

Put simply, public health data is a mess. A striking example is the incomplete and inconsistent COVID-19 case counts and death tallies, which is addressed by bills authored by Representatives Castor, Speier, and Bera.

Beyond COVID-19, inconsistent public health data have been raised repeatedly as an issue before this subcommittee in hearings. An example of this is that there is not a single standard for how to define a gun death or maternal death. My legislation with Representative Peters carries out several recommendations from the GAO and the National Academies of Science to make vital health statistics electronically available and comparable.

Robust and accessible public health data is a critical tool for State and local officials in their efforts to address the social determinants of health that perpetuate the inequities in our commu-

nities. Representative Barragán’s Improving Social Determinants of Health Act builds and complements the Health STATISTICS Act by authorizing a new CDC program that would use the improved and available health data to address structural challenges, such as unsafe housing, poor transportation, or food deserts.

The remaining bills work together to use public health data to address health disparities starting at conception through childhood, and into adulthood. I am proud that our subcommittee is once again leading the charge in a bipartisan way to promote health equity through evidence-based, data-driven policy.

Taken together, these 13 bills will make real and lasting change to rebuild our public health system so we can address both new health emergencies, like COVID–19, as well as the systemic issues of poverty and inequality.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

“Underfunded and under threat.” That was the Associated Press and Kaiser Health News’ indictment of the U.S. public health system based on their award-winning investigation last year.

The investigation found that since 2010, spending for state public health departments dropped by 16% per capita and spending for local health departments fell by 18%. At least 38,000 state and local public health jobs have disappeared since the 2008 recession.

Our hollowed-out public health system explains why we’ve seen COVID–19 cases tracked using fax machines and COVID–19 vaccines recorded on white paper cards.

These antiquated methods are embarrassing for a nation that once had a globally respected public health system, and our disarrayed data collection has broader consequences for many Americans. It has allowed racial health disparities to flourish without intervention. As the common maxim goes “you can’t manage what you can’t measure.”

The 13 bills our Subcommittee is considering today begin to rebuild our public health systems beyond pen-and-paper data collection and inconsistent definitions. Several of the bills use data to help our health systems improve the overall health and wellness of local populations rather than treat individual sickness.

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I’m proud that our Subcommittee is once again leading the charge in a bipartisan way to promote health equity through evidence-based, data-driven policy. Taken together, these 13 bills will make real and lasting change to rebuild our public health system so we can address both new health emergencies like COVID–19, as well as the systemic issues of poverty and racial inequality.

Ms. ESHOO. The Chair now is pleased to recognize our ranking member of the subcommittee, Mr. Guthrie, for 5 minutes——

Mr. BURGESS. Madam Chair? Madam Chair? This is Burgess. I wonder if I could just ask for a point of personal privilege before Mr. Guthrie is recognized.

Ms. ESHOO. Certainly.

Mr. BURGESS. Several people on this subcommittee are old enough to remember when we had a different subcommittee chair. And it was at that time that I was assisted so ably by my young staff.

Elizabeth Allen is going to be leaving my office now. She has accepted a position at Boston College to get an MBA, and it is quite a step—needless to say, quite a step up for her.

We have all benefited from her experience and her knowledge over the time that she has been associated with the Health Subcommittee's work. So I thought, if I could, I would just like to acknowledge the service of Elizabeth Allen, and perhaps we could give her a brief round of applause.

Ms. ESHOO. Absolutely, thank you.

[Applause.]

Ms. ESHOO. And we thank her for her wonderful service and wish her well.

The Chair now recognizes the wonderful ranking member of our subcommittee, Mr. Guthrie.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you. Thank you, Chair Eshoo, and thanks to Elizabeth. And I always enjoyed working with her, as well.

So thank you for your hard work, and good luck at Boston College.

And thanks for holding this important hearing today.

Before us today we have several bills pertaining to social determinants of health, as well as collecting health data. I look forward to hearing from the witnesses regarding these bills.

As currently defined by the CDC, social determinants of health are conditions and places where people live, learn, work, and play that affect a wide range of quality-of-health and quality-of-life risks and outcomes. I have seen and heard, firsthand, the benefits that Medicare Advantage can do to help address social determinants of health for seniors.

For example, a recent study showed that Medicare Advantage plans continue to offer benefits that help Americans with their social determinants of health. Specifically, the study found 27 percent of Medicare Advantage plans offered in-home services; 57 percent offered meal delivery; 57 percent offered transportation services; and 11 percent offered home modification. Additionally, they found that 94 percent of plans now offer telehealth as a base benefit. These benefits can continue without policy changes or site-of-service restrictions, postpandemic.

Since 2015 I have led the bipartisan Member letter in support of Medicare Advantage. In 2020 we had over 300 Members sign the annual letter to HHS in support of the program. It has been a bi-

partisan effort, and I want to take this opportunity to thank Representatives Cárdenas, Blumenauer, and Kelly for all of their hard work on this letter.

Medicare Advantage has demonstrated how successful private insurance plans can be, if given the proper flexibilities—that is, if my colleagues do not force Medicare for All on all Americans and take away this choice for nearly 29 million beneficiaries—nearly half of the eligible Medicare population that is—is estimated to choose MA for 2022. Medicare for All would prevent Americans from choosing this option that provides quality healthcare and supplemental services and helps address social determinants of health.

Medicare for All will lead to worst-case scenario for seniors, longer wait times, and diminished patient control over their own healthcare.

Today we are considering several health bills—health data bills. Useful health data is important, but some of the bills before us today are too narrow in scope and are duplicative of current efforts. In addition, it does not seem there is a consensus on what—who needs to collect what data, how it will be used, and who will have access to it, and how to do that in a way that doesn't add more administrative expense.

COVID-19 shed light on the need for more public health data infrastructure, and we must use lessons learned to prepare for future pandemics rather than continuing to focus on COVID-19's specific authorities and programs.

For example, H.R. 778 would establish new CDC grants to States that choose to develop and use digital contact tracing technology for COVID-19, which seems duplicative of programs that have already been funded in response to the pandemic. CDC has already received funds to do just that, and we should first evaluate how those funds are being spent.

Additionally, H.R. 791, the Tracking COVID-19 Variants Act, includes provisions that will require the CDC to issue guidance regarding collaborations in data sharing for COVID-19 sequencing while further enacting a pilot program by expanding existing data linkages. Data sequencing is already being done on variants today.

Further, H.R. 976, the ETHIC Act, would retroactively require States to report specific COVID-19 data to the CDC as a condition on receiving certain COVID-19 funding. Currently, States are already required to report some of this data.

I am looking forward to examining and building on ideas like Mr. Curtis' bipartisan legislation, H.R. 3969, which would allow spending on social determinants of health to be included in health insurance plans' medical loss ratio calculation, so to encourage Medicare Advantage and Medicare managed care organizations to take further action to support social determinants of health.

I support Dr. Burgess' bill, the Social Determinants of Health Data Analysis Act, which would require GAO to report on the actions taken by the Secretary of HHS to address social determinants of health.

In closing, I hope we can work in a bipartisan way to improve America's public health infrastructure so we are better prepared and ready to address the next pandemic. As we continue working, we need to ensure Americans' hard-earned taxpayer dollars are

being used efficiently and not on duplicate efforts. I look forward to having a productive discussion today on how to have better healthcare data and address social determinants of health.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

Thank you, Chair Eshoo, for holding this important hearing today.

Before us today we have several bills pertaining to social determinants of health (SDOH) as well as collecting health data. I look forward to hearing from the witnesses regarding these bills.

As currently defined by the CDC, social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. I have seen and heard firsthand the benefits that Medicare Advantage can do to help address social determinants of health for seniors.

For example, a recent study showed that Medicare Advantage plans continue to offer supplemental benefits that help Americans with their social determinants of health. Specifically, the study found 27% of MA plans offered in-home services, 57% offered meal delivery, 57% offered transportation services, and 11% offered home-modification. Additionally, they found that 94% of plans now offer telehealth as a base benefit. These benefits can continue without policy changes or site of service restrictions post-pandemic.

Since 2015, I have led the bipartisan member letter in support of MA. Historically, we have had record numbers of members join these efforts. In fact, in 2020, we had over 300 members sign the annual letter to HHS in support of the program. It has been a bipartisan effort, and I want to take this opportunity to thank Representatives Cárdenas, Blumenauer, and Kelly for all their hard work on this letter. Medicare Advantage has demonstrated how successful private insurance plans can be if given the proper flexibilities.

That is, if my colleagues do not force Medicare for All on Americans and take away this choice for the nearly 29 million beneficiaries—nearly half the eligible Medicare population that is estimated to choose MA for 2022. Medicare for All would prevent these 29 million Americans from choosing this option that provides quality healthcare and supplemental services that help address social determinants of health. Medicare for All will lead to worse care for seniors, longer wait times, and diminish patient control over their own healthcare.

Today we are also considering several health data bills. Useful health data is important, but some of the bills before us today are too narrow in scope to address future pandemics and are duplicative of current efforts. In addition, it does not seem there is a consensus on who needs to collect what data, how it will be used, and who will have access to it, and how to do that in a way that doesn't add more administrative expense to our costly healthcare system. COVID-19 shed light on the need for more public health data infrastructure, and we must use lessons learned to prepare for future pandemics rather than continuing to focus on COVID-19 specific authorities and programs.

For example, H.R. 778 would establish new CDC grants to states that choose to develop and use digital contact tracing technology for COVID-19 contact tracing program efforts, which seems duplicative of programs that have already been funded in response to the COVID-19 pandemic. CDC has already received funds to do just that, and we should first evaluate how those funds have been spent.

Additionally, H.R. 791, the Tracking COVID-19 Variants Act includes provisions that would require the CDC to issue guidance regarding collaborations and data-sharing for COVID-19 sequencing, while further enacting a pilot program by expanding existing data linkages. Data sequencing is already being done on variants today.

Further, H.R. 976, the ETHIC Act would retroactively require states to report specific COVID-19 data to the CDC as a condition of receiving certain COVID-19 funding. Currently, states are already required to report some of this data.

I'm looking forward to examining Mr. Curtis' bipartisan legislation, H.R. 3969, which would allow spending on social determinants of health to be included in health insurance plans' medical loss ratio calculation. I'm also interested in hearing how we can build on ideas like H.R. 3969 to encourage other insurance plans, like Medicare Advantage and Medicaid Managed Care Organizations, to take further actions to support social determinants of health.

I'm also looking forward to discussing Dr. Burgess' bill, the Social Determinants of Health Data Analysis Act, which would require the GAO to report on the actions taken by the Secretary of HHS to address social determinants of health.

In closing, I look forward to working in a bipartisan way to help improve America's public health infrastructure, so we are better prepared and ready to address the next pandemic. As we work on this, we need to ensure Americans' hard-earned taxpayer dollars are being used efficiently and not on duplicate efforts. I look forward to having a productive discussion today on how to have better healthcare data and address social determinants of health.

Mr. GUTHRIE. And I yield back my time.

Ms. ESHOO. The gentleman yields back. The Chair now is pleased to recognize the chairman of the full committee, Mr. Pallone, for his 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairwoman Eshoo.

Throughout the COVID-19 pandemic, Federal, State, and local public health leaders have faced barriers to collecting and discussing the data needed to fully respond to a public health crisis. It is this vital data that provides government officials and health leaders the critical insight needed to develop the best guidance in response to public health crises. And as a result of these barriers, public health departments at all levels of government have, at times, lacked the information they needed to better understand the significant impacts of the pandemic on our most vulnerable communities.

Unfortunately, the U.S. public health surveillance infrastructure was fragmented and inconsistent long before this COVID pandemic. Insufficient funding, limited resources, inadequate training, combined with differing State and county laws and nonexistent data standardization procedures, are several of the many factors that limit public health data.

The slate of bills we are considering today will make targeted improvements across three key areas. First, we will discuss establishing a uniform Federal strategic action plan, as well as data standards and a data sharing policy. Second, several of the bills we are considering will improve the collection of public health data that reveals the drivers of health inequities. And third, we will discuss proposals to assist States in the creation of a public health data infrastructure necessary to appropriately deploy resources and essential interventions.

I want to commend the chair and the sponsors of these bills for their leadership in advancing policy solutions for some of our country's most pressing health policy concerns.

Public health data is essential to the health of our country. It may not seem very interesting, but it is very important. This data allows us to understand which communities need resources, how many, and when. It allows us to better target health inequities and address them accordingly. Public health data also gives government and local leaders the ability to make upstream policy changes and implement prevention work.

Now, many of the bills we will discuss today also address the importance of better understanding and researching social deter-

minants of health to improve the overall health status of the United States. These bills take steps to eliminate the lingering health inequities that exist and burden some of our most vulnerable communities.

Uniform data collection is imperative to better understanding the inequities in our healthcare system and to guide real change. To effectively adapt interventions designed to advance health equity, we have to be able to standardize and collect data related to key social conditions. We will hear from the witnesses today about legislation that will help give States the tools they need to design effective interventions to address certain social determinants of health. These interventions will also improve the health and well-being of some of our most vulnerable populations, including by expanding access to evidence-based tobacco cessation treatment through the Medicaid program.

In finding comprehensive solutions to our fragmented public health data is of the utmost importance. With resources that Congress has provided through the COVID-19 relief packages, including the CARES Act and the American Rescue Plan, we know that data modernization is underway, and we must now continue that work to ensure that research labs, providers, and public health departments are working with real-time current data and have a better understanding of social determinants of health.

So I look forward to hearing from our witnesses and working together with our colleagues on these legislative proposals today.

Chairwoman Eshoo, I just want to say to you and the ranking member, you know, we are now—you know, the pandemic, hopefully, is winding down. But the pandemic showed us that, whether it was the public health infrastructure or the data collection—you know, I am talking about State labs, the supply chain, so many things that really showed that—need a lot of work, and didn't work well during the pandemic.

And so I think that—I just want everyone to know that myself and the members of this committee—and I know you, in particular, Ms. Eshoo—we want to get to the bottom of this and make sure that we are better prepared in the future, for future pandemics. And that is going to mean a lot in terms of, you know, things that maybe don't sound very interesting but are important, like data collection, like infrastructure for public health, like the State labs, like the supply chain. It is only if we can improve those things that we can be better prepared for future pandemics, and I just want to stress that today.

I don't know how much the media cares about this, but it is very important, it really is, and that is what I wanted to stress.

So thank you, I yield back.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Throughout the COVID-19 pandemic, Federal, State, and local public health leaders have faced barriers to collecting and accessing the data needed to fully respond to a public health crisis. It is this vital data that provides government officials and health leaders the critical insight needed to develop the best guidance and response to public health crises. As a result of these barriers, public health departments at all levels of government have, at times, lacked the information they needed to better

understand the significant impacts of the pandemic on our most vulnerable communities.

Unfortunately, the U.S. public health surveillance infrastructure was fragmented and inconsistent long before this pandemic. Insufficient funding, limited resources, inadequate training combined with differing state and county laws, and nonexistent data standardization procedures are several of the many factors that limit public health data.

The slate of bills we are considering today will make targeted improvements across three key areas. First, we will discuss establishing a uniform, federal strategic action plan, as well as data standards, and data sharing policies. Second, several of the bills we're considering will improve the collection of public health data that reveals the drivers of health inequities. And third, we will discuss proposals to assist states in the creation of the public health data infrastructure necessary to appropriately deploy resources and essential interventions.

I commend the Chair and sponsors of these bills for their leadership on advancing policy solutions for some of our country's most pressing health policy concerns. Public health data is essential to the health of our country. This data allows us to understand which communities need resources, how many and when. It allows us to better target health inequities and address them accordingly. Public health data also gives government and local leaders the ability to make upstream policy changes and implement prevention work.

Many of the bills we will discuss today also address the importance of better understanding and researching social determinants of health to improve the overall health status of the United States. These bills take steps to eliminate the lingering health inequities that exist and burden some of our most vulnerable communities.

Uniform data collection is imperative to better understanding the inequities in our healthcare system and to guide real change. To effectively adapt interventions designed to advance health equity, we must be able to standardize and collect data related to key social conditions.

We will hear from the witnesses today about legislation that will help give states the tools they need to design effective interventions to address certain social determinants of health. These interventions will also improve the health and well-being of some of our most vulnerable populations, including by expanding access to evidence-based tobacco cessation treatment through the Medicaid program.

Finding comprehensive solutions to our fragmented public health data is of the utmost importance. With resources that Congress has provided through COVID-19 relief packages, including the CARES Act and the American Rescue Plan, we know that data modernization is underway. We must now continue that work to ensure that research labs, providers and public health departments are working with real-time, current data and have a better understanding of social determinants of health. I look forward to hearing from our witnesses and working together with my colleagues on the legislative proposals before us today.

Thank you, I yield back.

Ms. ESHOO. Thank you, Chairman, and it is exactly why we are bringing these 13 bills forward, and have the outstanding witnesses that are with us today to give us their opinion, given their background and experience.

The Chair now is pleased to recognize the ranking member of the full committee, Congresswoman Cathy McMorris Rodgers, for her 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. CATHY McMORRIS RODGERS,
A REPRESENTATIVE IN CONGRESS FROM THE STATE OF
WASHINGTON**

Mrs. RODGERS. Thank you, Madam Chair.

Social and economic conditions have a powerful influence on our health and well-being. Dependable transportation, job security, and access to healthy foods are all factors that make a difference in the prevention and management of many conditions like diabetes, heart disease, and obesity.

Today 9.3 million Americans are currently on the sidelines and out of work. Unemployed individuals are more likely to suffer from

illnesses such as high blood pressure, stroke, heart attack, and arthritis. Unemployment leads to worse health outcomes, on average, for all workers, regardless of their baseline measure of health. It is a cycle of despair that must be broken to promote healthier families.

We need to get Americans back to work. People need hope and a purpose. It means more than a job. It is about dignity and the opportunity for a better life. And we are only at the beginning of understanding the impact of the pandemic lockdowns on mental health. This is a crisis. One hospital I talked to said social isolation is the biggest concern for seniors, not to mention the rise in mental health emergencies that we have seen for our children.

For hope and real results, we should be looking to how the private sector and communities are leading the way for healthier futures. In my district, to help people without transportation, Washington State University partnered with Range Health to purchase a mobile health unit to provide primary care, noninvasive procedures, and preventative screenings for underserved, rural communities. Some ride share apps are also allowing eligible patients to order rides to and from doctors' appointments, often paid for by health insurance companies. Meal delivery services are also helping seniors access nutritional food. And Medicare Advantage offers coverage options for these services.

According to a recent CMS report, 60 percent of Medicare Advantage beneficiaries are enrolled in a plan that offers food assistance. The number of seniors that choose Medicare Advantage plans offering these supplemental benefits like food assistance, housing, pest control tripled between 2020 and 2021. I look forward to listening to and learning more from our witnesses today on how Medicare Advantage flexibilities are helping address social determinants of health in our seniors and what more that we can do to incentivize the private sector.

In 2021 Medicare Advantage plans covered 26 million people, which is a little over 40 percent of the entire Medicare population. Seniors from all walks of life are choosing these private-run plans over government-run fee-for-service plans. They are spending less and getting better preventative care because of it.

I am extremely concerned by proposals from my Democrat colleagues that would ban Medicare Advantage plans and move everyone to a one-size-fits-all, government-run plan. The Federal Government should provide incentives and enable the private sector to tackle these social determinants in a way that empowers local communities. However, as we look at data policies, we need to be very clear with the American people about who is collecting what data and how it will be used.

Some of the bills today authorize enormous sums of money before we even have a clear understanding of what the private sector, State, local, and Federal Government is already doing and what is working. That approach may work in scoring some political points, but it doesn't drive results.

I also have concerns continuing short-sighted, COVID-19-specific legislation. I recently spoke with former CDC Director Dr. Redfield. He said that the big pandemic is yet to come. We don't know that it will be coronavirus, pandemic flu, or something entirely new. We

need to be working on preparing data systems and public health for all threats, not just COVID, and take into account where these systems are after the large investment and lessons learned from COVID-19.

We should be empowering innovative methods that are backed by trust—trusted data—to address social determinants of health. Doctors, hospital, State and local governments, communities groups, and health insurers are leading the way, tackling social determinants of health. We need to enable their continued leadership and success and remove any arbitrary roadblocks.

[The prepared statement of Mrs. Rodgers follows:]

PREPARED STATEMENT OF HON. CATHY MCMORRIS RODGERS

SOCIAL DETERMINANTS OF HEALTH

Thank you, Madam Chair.

Social and economic conditions have a powerful influence on our health and well-being.

Dependable transportation, job security, and access to healthy foods are all factors that make a difference in the prevention and management of many conditions like diabetes, heart disease, and obesity.

Today, 9.3 million Americans are currently on the sidelines and out of work.

Unemployed individuals are more likely to suffer from illnesses such as high blood pressure, stroke, heart attack, and arthritis.

Unemployment leads to worse health outcomes on average for all workers, regardless of their baseline measures of health.

It's a cycle of despair that must be broken for healthier families.

We need to get Americans back to work.

People need hope... and a purpose. It means more than just a job. It's about dignity and the opportunity for a better life.

And we're only just beginning to understand the impact of pandemic lockdowns on mental health.

This is a crisis. One hospital I talked to said social isolation is the biggest concern for seniors...

...not to mention the rise in mental health emergencies we've seen for our kids.

For hope and real results, we should be looking to how the private sector and communities are leading the way for healthier futures. .

PRIVATE SECTOR

In my district, to help reach people without transportation, Washington State University partnered with Range Health to purchase a mobile health unit to provide primary care, noninvasive procedures, and preventative screening for underserved, rural communities.

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The number of seniors that chose Medicare Advantage plans offering these "supplemental benefits," like food assistance, housing, pest control tripled between 2020 and 2021.

I look forward to listening to and learning more from our witnesses today on how Medicare Advantage flexibilities are helping address social determinants of health in our seniors...

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In 2021, Medicare Advantage plans cover 26 million people, which is a little over 40 percent of the entire Medicare population. Seniors from all walks of life are choosing these private run plans over government run fee-for-service plans.

They are spending less and getting better preventive care because of it.

I'm extremely concerned by proposals from Democrat colleagues that would ban Medicare Advantage plans and move everyone to a one-size-fits all government run plan.

Concerns with Legislation

The federal government should provide incentives and enable the private sector to tackle these social determinants in ways that empower local communities.

However, as we look at data policies, we need to be very clear with the American people about who is collecting what data, and how it will be used.

Some of the bills today authorize enormous sums of money before we even have a clear understanding of what the private sector, state, local, and federal governments are already doing and what is working.

That approach may work to score political points, but it doesn't drive real results. I also have concerns continuing short-sighted COVID-19 specific legislation. I recently spoke with former CDC Director Robert Redfield.

He said the big pandemic is yet to come.

We don't know if that will be a coronavirus, pandemic flu, or something entirely new.

We need to be working on preparing data systems and public health for all threats, not just COVID, and take into account where these systems are after the large investment and lessons learned from COVID-19.

CONCLUSION

We should be empowering innovative methods—that are backed by trusted data—to address social determinants of health.

Doctors, hospitals, state and local governments, community groups, and health insurers are leading the way in fighting social determinants of health.

We need to enable their continued leadership and success and remove any arbitrary roadblocks.

I'm looking forward to today's discussion and I yield back.

Mrs. RODGERS. I am looking forward to today's discussion, and I yield back.

Ms. ESHOO. The gentlewoman yields back. I thought I knew just about everything in terms of benefits in Medicare Advantage. I didn't know that pest control was one of them.

The Chair would like to remind Members that, pursuant to committee rules, all Members' written opening statements will be made part of the record.

I now would like to introduce our witnesses.

Dr. Karen DeSalvo is the chief health officer for Google Health. She previously served as the Acting Assistant Secretary for Health and the national coordinator for health information technology at HHS.

Welcome, Dr. DeSalvo, we are thrilled to have you with us.

Dr. Romilla Batra is the chief medical officer for the SCAN Health Plan, which is one of our Nation's largest not-for-profit Medicare Advantage plans.

Welcome to you.

Ms. Beth Blauer is the assistant vice provost for public sector innovation and the data lead for the Johns Hopkins University's Coronavirus Resource Center.

Welcome to you. We look forward to your testimony.

Dr. Faisal Syed is the national director of primary care for ChenMed, which is a fully capitated primary care practice for seniors. He is also testifying on behalf of the America's Physician Groups.

Welcome to you, and we all look forward to your testimony.

And Dr. Kara Odom Walker, who is the executive vice president and the chief population health officer for the Nemours Children's Health System.

So welcome to each one of you. The entire subcommittee is very grateful that you have agreed to testify.

And Dr. DeSalvo, you have—you are recognized for 5 minutes for your testimony, and please unmute.

STATEMENT OF KAREN B. DeSALVO, M.D., CHIEF HEALTH OFFICER, GOOGLE HEALTH; ROMILLA BATRA, M.D., CHIEF MEDICAL OFFICER, SCAN HEALTH PLAN; BETH I. BLAUER, EXECUTIVE DIRECTOR, JOHNS HOPKINS UNIVERSITY CENTERS FOR CIVIC IMPACT; FAISEL SYED, M.D., NATIONAL DIRECTOR OF PRIMARY CARE, CHENMED; AND KARA ODOM WALKER, EXECUTIVE VICE PRESIDENT AND CHIEF POPULATION HEALTH OFFICER, NEMOURS CHILDREN'S HEALTH SYSTEM

STATEMENT OF KAREN B. DeSALVO, M.D.

Dr. DeSALVO. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the committee. I appreciate the opportunity to appear today. My name is Dr. Karen DeSalvo, and I am a physician and former local and national public health official who has spent my career working at the intersection of clinical care, public health, and digital innovation to improve the conditions in America's most vulnerable communities.

Currently I serve as the chief health officer at Google and remain engaged in efforts to address the public's health collaboratively, including through my role as coconvener of the National Alliance to Impact the Social Determinants of Health with former HHS Secretary, Michael Leavitt and as a member of the Robert Wood Johnson Foundation National Commission to Transform Public Health Data Systems.

Today's hearing takes place at an historic moment, as we chart the road to recovery from the greatest public health emergency in over a century. I applaud the subcommittee for their leadership during the pandemic and for advancing a bold vision for public health transformation that intersects with data modernization and health equity. The vision recognizes how COVID-19 pulled back the curtain on the structural failings that contribute to inequities in our current public health system: chronic underfunding, obsolete digital infrastructure, and longstanding capacity gaps.

I have seen these shortcomings firsthand. That is why I believe building resilient and equitable public health systems begins with crosscutting solutions, a theory of change that is captured in the Public Health 3.0 framework. I am excited that many of the proposed bills in today's hearing share this ethos, and offer the following recommendations to inform the subcommittee's vital work.

First, while data analytics and IT infrastructure are important, it is imperative that legislation and policymaking focus on the systems that collect, exchange, and act on data, rather than the data itself. Recently proposed legislation for the Public Health Infrastructure Fund highlights the stable foundation of resources that health departments will need, from infrastructure upgrades to workforce investments and operational design.

Second, public-private partnerships can maximize the value of data for governmental public health. There are numerous examples of such partnerships during COVID-19. To optimize these beyond the pandemic, we need to develop data infrastructure within public health focused on racial and rural disparities like the ones proposed in the bills today.

Third, achieving equity requires expanding our understanding of what data can be useful. Projects like our Google COVID-19 Search Symptoms Trends show how public health can leverage novel data signals in a privacy-preserving manner to inform research and public health decision making, such as where to dedicate more resources. In addition, data systems aimed at addressing inequities should integrate sources from the social and human services sectors.

Fourth, data systems need to be built to describe and address inequities, not only at the individual level but at the system level too. For example, knowing that kids in a certain neighborhood are unhealthy is just one step. But understanding where kids might not have access to sidewalks and playgrounds could help communities take action.

Fifth and finally, the CDC's data modernization initiative would benefit from incorporating the lessons learned from high tech, the opportunities to do more than rewire the current 20th century public health systems, but to reimagine it. 21st Century Cures articulated such a vision by advocating the use of open—standards and FHIR-based application programming interfaces, or APIs, for the healthcare system. The same can be used for public health.

We should also ensure that States and localities are not rushed in spending the funds and that they have an appropriately resourced workforce to maximize impact.

In closing, I want to reiterate my thanks for the opportunity to testify and emphasize the critical importance of the topics covered in today's hearing. I look forward to working with the subcommittee on opportunities to strengthen our Nation's public health infrastructure to achieve health for all equitably. I look forward to your questions.

[The prepared statement of Dr. DeSalvo follows:]

Written Testimony of
Karen B. DeSalvo, MD, MPH, MSc

House Committee on Energy and Commerce
Subcommittee on Health
Empowered by Data: Legislation to Advance Equity and Public Health
June 24, 2021

Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Committee: thank you for the opportunity to appear today. My name is Dr. Karen DeSalvo, and I am a physician and former local and national public health official who has spent my career working at the intersection of clinical care, public health, and digital innovation to improve the conditions in America's most vulnerable communities. Currently, I serve as the Chief Health Officer at Google and remain engaged in efforts to address the public's health collaboratively, such as through my role as co-convenor of the National Alliance to Impact the Social Determinants of Health with former HHS Secretary Michael O. Leavitt and as a member of the Robert Wood Johnson Foundation National Commission to Transform Public Health Data Systems.

It is an honor to testify today and share my experiences and perspectives on how the nation can better leverage data to advance equity and public health. While COVID-19 may be caused by a novel pathogen, the inequities exposed by the pandemic have long been endemic to our society. The elevated risk of exposure, severe illness, and mortality in marginalized populations reflects both generational resource gaps and the effects of social and structural determinants of health, including racism.^{1,2} I applaud the Subcommittee for their leadership during COVID-19, including the passage of transformative pandemic relief legislation to

¹ Romano, Sebastian D. "Trends in Racial and Ethnic Disparities in COVID-19 Hospitalizations, by Region—United States, March–December 2020." *MMWR*, 70 (2021).

² Asch, David A., et al. "Patient and Hospital Factors Associated With Differences in Mortality Rates Among Black and White US Medicare Beneficiaries Hospitalized With COVID-19 Infection." *JAMA Network Open* 4.6 (2021): e2112842–e2112842.

reinforce the nation's public health infrastructure, expand access to testing and vaccines, and pave the road to recovery from this public health emergency.

These barriers to equity are not new to those of us working in medicine and public health.³ I learned about them from my patients at Charity Hospital, a safety net system in New Orleans, that was closed in wake of the devastation of Hurricane Katrina. Katrina, like COVID-19, opened policymakers' eyes to pre-existing inequities.⁴ In response, we rallied to create a system with the community: one capable of both addressing ongoing health challenges and moving upstream to address the social and structural determinants of health responsible for a life expectancy gap of 25 years for people living just a few miles apart. Addressing these inequities required shifting our focus from individual patients to population-level data, which revealed disparities beyond medical care (e.g., access to healthy food, quality education, housing, and transportation).⁵

This experience opened my eyes to how inequities are driven by context and must be mitigated by investments in infrastructure, in addition to individuals. It also spurred my understanding of how critical it is to have timely, granular, actionable data that can not only describe the problems, but also guide effective interventions. In 2005, such data was rarely available because our health care system, like most in the US, relied on paper-based records, which were consequently lost amidst the flooding and resulted in discontinuity of care.⁶ These experiences motivated Louisiana to be a national leader in the adoption of electronic health records to improve the care of individuals, drive an opportunity for equity, and steer public

³ Marmot, Michael, and Jessica J. Allen. "Social Determinants of Health Equity." (2014): S517-S519.

⁴ Van Spall, Harriette GC, Clyde W. Yancy, and Keith C. Ferdinand. "COVID-19 and Katrina: Recalcitrant Racial Disparities." (2020): 3390-3393.

⁵ The New Orleans Health Disparities Initiative. "Rebuilding a Healthy New Orleans". 2007. Accessed June 21, 2021. Available at: https://www.prrac.org/pdf/rebuild_healthy_nola.pdf.

⁶ Dimick, Chris. "Long Recovery: HIM Departments Three Years after Katrina". *Journal of AHIMA* 79.9 (September 2008): 42-46.

health action.⁷

The need to leverage more than the health care system to address systemic health inequities in New Orleans motivated me to serve as the Health Commissioner in New Orleans. Like all local health officers, it is a role in which the community becomes your patient with a charge to serve everyone who lives, learns, works and plays in the jurisdiction. I saw my mission as working across sectors, with housing, education, business, the faith-based community and more, to build a more equitable and resilient community that would drive health for all.

Yet I also quickly learned an important lesson. Building public health programs purely on the available population-level data would be insufficient. First, the data available to me was stale—often at least two years old—and provided at best a look in the rearview mirror rather than a pulse of current community challenges or forecasts into the future. Second, relying on quantitative data alone could only tell me what diseases existed in the medical system, and not what was driving health challenges for my community. I sought to supplement quantitative data with qualitative data gathered from conversations in church halls, community centers, and playgrounds; all of which encouraged me to look beyond the headlines of cardiovascular disease and cancer and elevate our focus on addressing violence, mental health, and the lack of economic opportunity. In order to meet the community where they were, we needed to create a public health system capable of blending timely quantitative data with the public voice to generate actionable insights for health.

I carried these lessons with me to my subsequent service in the federal government, where, for nearly two years, I held the dual roles of National Coordinator for Health Information

⁷ Taylor, Shayne Sebold, and Jesse M. Ehrenfeld. "Electronic Health Records and Preparedness: Lessons from Hurricanes Katrina and Harvey." *Journal of Medical Systems* 41.11 (2017): 1-1.

Technology and Assistant Secretary for Health (Acting). This unique experience allowed me to see the power and potential of technology and public health to address major health challenges at scale. As electronic health records became more pervasive, we saw examples of how this “novel” data could identify public health crises and support everyday public health surveillance needs. For example, it was data from hospital records—which are normally inaccessible to public health—that enabled health officials to sound the alarm about the Flint water crisis in Michigan.⁸ Another example is Project Macroscopic, which enables New York City’s health department to leverage primary care clinic electronic health record data for chronic disease surveillance on par with community surveys.⁹

Many of these new insights came from the medical system, which has been successfully digitized thanks to the investments and incentives of the HITECH Act. However, public health was excluded from accessing those resources for IT modernization resourcing, meaning America’s health departments never developed a 21st century data infrastructure.¹⁰ As we saw acutely during the pandemic, the public health system continues to rely on paper, fax machines, and spreadsheets.¹¹ Yet the challenge for the public health system is broader than simply an outmoded data and IT infrastructure. For a variety of reasons including chronic under-resourcing, the increasing complexity of caring for marginalized populations, and broadening scope of practice, public health has struggled to keep up with programmatic expectations, leaving little opportunity for visioning and modernization. This was certainly what I experienced as a local health officer in New Orleans. We had a dedicated and talented staff,

⁸ Hanna-Attisha, Mona, et al. “Elevated Blood Lead Levels in Children Associated with the Flint Drinking Water Crisis: A Spatial Analysis of Risk and Public Health Response.” *American Journal of Public Health* 106.2 (2016): 283-290.

⁹ Perlman, Sharon E., et al. “Innovations in Population Health Surveillance: Using Electronic Health Records for Chronic Disease Surveillance.” *American Journal of Public Health* 107.6 (2017): 853-857.

¹⁰ Lenert, Leslie, and David N. Sundwall. “Public Health Surveillance and Meaningful Use Regulations: A Crisis of Opportunity.” *American Journal of Public Health* 102.3 (2012): e1-e7.

¹¹ Kliff, Sarah, and Margot Sanger-Katz. “Bottleneck for U.S. Coronavirus Response: The Fax Machine”. *The New York Times*. July 13, 2020. Accessed June 21, 2021. Available at: <https://www.nytimes.com/2020/07/13/upshot/coronavirus-response-fax-machines.html>.

struggling mightily with structural challenges that made it difficult to address expected public health issues, much less manage major crises such as a pandemic. I learned from my colleagues that this same narrative was playing out in the thousands of state and local health departments across America.

At HHS, we sought to synthesize the innovative work on the frontlines into a comprehensive vision for transforming America's public health infrastructure. The resulting framework, known as Public Health 3.0, is grounded in a commitment to equity, informed by prior reports by the National Academy of Medicine, and composed of five critical elements based on community listening sessions hosted across the U.S: strong leadership & workforce; strategic partnerships; flexible & sustainable funding; timely & locally relevant data, metrics & analytics; and foundational infrastructure.^{12,13,14}

The tenets of the Public Health 3.0 vision continue to be applicable today and, in fact, have become a guiding vision for transforming public health in America. Local health departments in places like Lawrence-Douglas County in Kansas and state health agencies such as Washington, Kentucky, and Pennsylvania have all incorporated the elements of 3.0 into their strategic visions.^{15,16,17} And the US public health enterprise has embraced the framework and call to action, building training programs, working to advance data systems, and rallying around a rational model for sustainable funding for a defined set of foundational capabilities that can be assessed in a structured accreditation program.¹⁸

¹² Institute of Medicine. 1988. *The Future of Public Health*. Washington, DC: The National Academies Press.

¹³ Institute of Medicine. 2003. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.

¹⁴ Institute of Medicine. 2012. *For the Public's Health: Investing in a Healthier Future*. Washington, DC: The National Academies Press.

¹⁵ KU Lifespan Institute. Health for the 21st Century Summit. February 1, 2018. Accessed June 21, 2021. Available at: <https://www.lsi.ku.edu/news/health-for-the-21st-century-summit>

¹⁶ Kentucky Public Health. "Kentucky Public Health Transformation Plan". September 9, 2019. Accessed June 21, 2021. Available at: <https://apps.legislature.ky.gov/CommitteeDocuments/7/11984/Sept%202019%20Public%20Health%20Transformation%20Handout.pdf>

¹⁷ Live Healthy PA. "Public Health 3.0". Accessed June 21, 2021. <https://www.livehealthypa.com/community/public-health-3-0>

¹⁸ DeSalvo, Karen, et al. "Developing a Financing System to Support Public Health Infrastructure." *American Journal of Public Health* 109.10 (2019): 1358-1361.

During COVID-19, we saw numerous examples of Public Health 3.0 in action.¹⁹ In particular, public health relied heavily on strategic partnerships, whether it was between health systems and health departments like Parkland and Dallas County in Texas or with insurers and health agencies to improve needs assessments like Blue Shield California's vulnerability index.^{20,21} Likewise, COVID-19 affirmed the importance of timely and locally relevant data, analytics, and metrics, especially in the context of equity. At Google, our partnership with Morehouse on health equity could be broadened to address disparities beyond COVID-19, while Google's support for tracking viral variants through [Global.health](#) could help map mutations and drug-resistance for other infectious diseases.^{22,23}

As the pandemic begins to wane, leaders have turned to Public Health 3.0 as a north star for guiding post-emergency reforms. For instance, recommendations from a recent expert review organized by the National Academy of Medicine and proposed legislation, including H.R. 379 which is in consideration before the Subcommittee today, have all been grounded in the Public Health 3.0 framework.^{15,20,24}

Achieving a shared vision of leveraging data to address equity through a modern public health system will take intentional, strategic, and organized efforts across multiple sectors and require collaboration between the public and private sector to identify needs, fill gaps, and take action. As this work unfolds, it seems clear that lessons from the past, and from this

¹⁹ DeSalvo, K., B. Hughes, M. Bassett, G. Benjamin, M. Fraser, S. Galea, N. Garcia, and J. Howard. 2021. Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202104c>

²⁰ Cerise, Frederick P., et al. "The Imperative for Integrating Public Health and Health Care Delivery Systems." *NEJM Catalyst Innovations in Care Delivery* 2.4 (2021).

²¹ McClellan, M., R. Rajkumar, M. Couch, D. Holder, P. Long, R. Medows, A. Navathe, M. Pham, L. Sandy, W. Shrank, and M. Smith. 2021. Health Care Payers COVID-19 Impact Assessment: Lessons Learned and Compelling Needs. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202105a>

²² Seabron, Chelsea. "Tracking Data to Advance Health Equity". May 26, 2021. Accessed June 21, 2021.

<https://blog.google/outreach-initiatives/google-org/health-equity-tracker/>.

²³ Ratcliffe, Stephen. "How Anonymized Data Helps Fight Against Disease". February 24, 2021. Accessed June 21, 2021.

<https://blog.google/outreach-initiatives/google-org/how-anonymized-data-helps-fight-against-disease/>.

²⁴ United States House of Representatives. Improving Social Determinants of Health Act of 2021.

<https://www.congress.gov/bills/117/congress/house-bill/379?sr=1&r=4>. 117th Congress, House Bill 379, introduced January 21, 2021.

pandemic, should inform our work. It also seems clear that we should develop a comprehensive system that will not only resource the federal public health entities but also support localities who know the community best. That system should be durable in design, sustainable in operations, and governed with appropriate accountability to the public. I offer a few actions that we should build into the strategic and tactical efforts at this profound moment in our nation's history.

First, while data analytics and IT infrastructure are important, it is imperative that legislation and policymaking focus on the *systems* that collect, exchange, and act on data rather than on the data itself. This will require a combination of infrastructure upgrades, workforce investments, and operational redesign. For example, we cannot expect health departments to forecast future pandemics if local health officials are still relying on fax machines to exchange data. Likewise, we cannot expect new data modernization initiatives to succeed if only 1% of health department roles are for informatics specialists.²⁵ For public health to reach new heights, health departments need a stable foundation of resources to stand upon. Recently proposed legislation for the Public Health Infrastructure Fund, which was developed as part of a larger body of work to operationalize the recommendations of Public Health 3.0, provides a roadmap for guiding generational investments in governmental public health.^{26,27}

Second, the expanding scope of practice for public health requires support from every sector of society. COVID-19 has highlighted the value of public-private partnerships, and we must build on these new ways of working to rethink the operating model for governmental

²⁵ Sellers, Katie, et al. "The Public Health Workforce Interests and Needs Survey: The First National Survey of State Health Agency Employees." *Journal of Public Health Management and Practice* 21.Suppl 6 (2015): S13.

²⁶ United States Senate. Public Health Infrastructure Saves Lives Act. <https://www.congress.gov/bills/117/congress/senate/bills/674>, 117th Congress, Senate Bill 674, introduced March 10, 2021.

²⁷ Levi, Jeffrey, and DeSalvo, Karen. Funding For Local Public Health: A Renewed Path For Critical Infrastructure. *Health Affairs Blog* (2017).

public health. For example, at Google we have partnered with Ariadne Labs at Harvard to develop a new Vaccine Equity Planner dashboard that helps integrate data from Google Maps API with data from the CDC and other public health organizations to identify and close disparities in COVID-19 vaccination rates.²⁸ If we are to achieve health for all, then we must encourage all parties to contribute to advancing equity in the public's health. H.R. 666, which is in consideration before the Subcommittee today, is an example of how we can develop infrastructure within public health to further leverage data to address the racial disparities in health exacerbated by COVID-19.^{2,29} To facilitate the translation of public health research into public health practice, Congress could consider implementing recommendations from the National Academy of Medicine to establish backbone entities for coordinating activities to address the upstream drivers of health at the regional and state level.²⁰

Third, achieving equity via data requires thinking more creatively about what data we leverage and the goals of the data systems themselves. The definition of public health data needs to be as broad as the purview of public health. Projects like our Google COVID-19 Search Symptom Trends illustrate how public health can leverage novel data signals in a privacy-preserving manner to address the upstream drivers of health and improve emergency preparedness.³⁰ Given that the gateway to health information for many people today is the internet—with 1-in-15 Google Searches even before the pandemic related to health—public-private partnerships for public health can help ensure users are able to access the right information at the point of need. Google's open data repository for COVID-19, for

²⁸ Ariadne Labs. "Vaccine Equity Planner Launched by Ariadne Labs and Boston Children's Hospital". June 9, 2021. Accessed June 21, 2021.

<https://www.prnewswire.com/news-releases/vaccine-equity-planner-launched-by-ariadne-labs-and-boston-childrens-hospital-301308562.html>.

²⁹ United States House of Representatives. Anti-Racism in Public Health Act of 2021.

<https://www.congress.gov/bills/117/congress/house-bill/666?rs=1&r=8>, 117th Congress, House Bill 666, introduced February 1, 2021.

³⁰ Gabrilovich, Evgeniy. "Using Symptoms Search Trends to Inform COVID-19 Research". September 2, 2020. Accessed June 21, 2021. <https://blog.google/technology/health/using-symptoms-search-trends-inform-covid-19-research/>.

instance, incorporates epidemiological and public population data from over 50 countries to facilitate collaboration across the research and public health community. In addition, data systems need to support the social and human services sectors and their critical work. These sectors have even weaker data and information technology capabilities than public health, yet are essential in providing a comprehensive approach to addressing inequities. A recent National Academy of Medicine Report, "Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health," provides key recommendations.³¹

Fourth, data systems need to be built to describe and address inequities, not only at the individual level, but also to address structural and systemic policies and systems that perpetuate inequities and poor health outcomes. Tobacco programs are a prime example. Yes, individual efforts to ensure access to smoking cessation programs are important. However, coupled with efforts like smoke-free campuses, they can not only help people stop smoking, but also prevent youth from beginning in the first place. A data system capable of tracking system policies could guide and inform interventions and progress.

Fifth and finally, the CDC's ongoing Data Modernization Initiative would benefit from incorporating the lessons of HITECH. The nation should not settle for rewiring current public health data systems but, rather, should rethink the ecosystem and create an opportunity for alignment on open data standards and support of digital innovation. For one, we should commit to creating an interoperable public health data system, including the use of open and non-proprietary standards and FHIR-based application programming interfaces like those expected for healthcare in 21st Century Cures. We should also ensure that states and localities are not rushed in spending the funds, but can do so with clarity on an inclusive, open data

³¹ National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25467>.

architecture and have a workforce in place with the capabilities and capacity to maximize impact.

In closing, I am reminded of the guiding ethos of Public Health 3.0: that “public health is what we do together as a society to ensure the conditions in which everyone can be healthy.” The work of the Subcommittee and this hearing today are things we all need to do together to act on the lessons of COVID-19 and build a more equitable and resilient public health system and, in turn, a more resilient population.

Thank you again for inviting me to participate in this discussion. We look forward to continued engagement with this Subcommittee on these important issues.

Ms. ESHOO. Thank you very much, Dr. DeSalvo.

Next, Dr. Romilla Batra, you are recognized for your 5 minutes of testimony.

STATEMENT OF ROMILLA BATRA, M.D.

Dr. BATRA. Thank you so much. Good morning, Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Health Subcommittee. My name is Romilla Batra. I am a primary care physician and chief medical officer of SCAN Health Plan. Thank you for giving me the opportunity to address how SCAN addresses social determinants of health, what supplemental benefits we provide, and our recommendations. My remarks will briefly cover who we are, how do we serve our members and our communities, and our focus on the older adult population at large.

SCAN stands for Senior Care Action Network. We were founded in 1977, and we are a not-for-profit MA plan. We are a mission-based organization, and our mission is keeping seniors healthy and independent. And the true story is it was started by 12 angry seniors who truly believed there was more to health than doctors and medications and nursing homes. They wanted to age in place and live in their communities. They were the true pioneers who knew why social determinants of health are so important to be fulfilled.

And since then we have taken care of that population. We have provided a special needs plan, and we are the only plan in California to offer a fully integrated, dual-eligible special needs plan. We serve about 220,000 beneficiaries in California, and we have been consistently CMS-ranked a 4.5-star plan, so we are really proud of the quality of care that we provide.

Addressing social determinants of health is really important to improve health outcomes, as these factors represent 70 percent of the drivers affecting a person's overall health status. We see that in studies. We see that also in our data. So our approach to addressing social determinants of health is identifying what the social risks are, stratifying the population so we can match them with programs and benefits, serving our members and clients, measuring the impact, scaling the programs, and, as a not-for-profit organization, running our own community-based organization in the community that serves older adults and their caregivers.

In terms of identification, we have consistently done health risk assessment to gather not only health data but also social needs data as well as demographic data. That is race and language, including newly started sexual orientation and gender identification data. We have data on 90 percent of our population on their race and language, which really helps us serving them better.

In terms of stratifying and serving them, we offer different programs. I would like to quickly highlight one of them. It is a member-to-member program, where we take our own members, who then are our employees, train them in motivational interviewing. They then engage with our members, help them around social isolation, addressing their social needs, mental health. Last year we were able to reach out to about 10,000 of our members through this program. We had a very high adoption rate of 50 percent, and saw a statistically significant improvement in things like incontinence, falls, physical activity, and social isolation.

On the other extreme, we also have programs like connecting provider to home, where we have a social worker and a community health worker from a community that addresses the needs of the top 1 percent of our population who have high social burden and high medical burden. A great story of Mr. M, who lived in a mobile home, had a history of falling, did not have access to food, did not have access to resources to pay for his utility bills. A community health worker was going—was able to stop in, helped with filling out forms for application for Medicare, get assistance from community around utility payments, able to connect them with benefits around food, as well as able to go over the doctor's appointment to help with the DME. Those are the kind of things that make a difference in terms of their health outcomes.

We continue following our data to find where there are unmet needs and addressing supplemental benefits to address them. In terms of our supplemental benefits, we are very grateful for the Congress for helping us do the flexibility. Because of the flexibility, we are able to offer multiple benefits. I will highlight one of them. It is called the Return to Home Benefit, which addresses the needs of older adults getting discharged to their home. We provide in-home caregiving, meals, homemaking services, care coordination to pick up that medication, as well as caregiving support.

Finally, my recommendation would be that, as a not-for-profit MA plan with a long history of serving older adults, these are very important needs. We ask that Congress include SDOH such as food insecurity to the criteria for supplemental benefits more broadly than only specific chronic conditions.

Finally, we recommend you consider supporting H.R. 2166, Ensuring Parity in MA and PACE for Audio-Only Telehealth bill. Wi-Fi access became a huge social determinant of health need during the pandemic, and digital divides were huge, so we truly believe this can make a difference.

There is also a Senate companion bill, Ensuring Parity in MA Audio—for Audio-Only that we would love—like to recommend.

On behalf of SCAN, thank you for your ongoing commitment to improving the care for older adults. We welcome the opportunity to be a resource to members of this committee, if you can be of service. Thank you again for the honor to speak before this distinguished committee. Thanks.

[The prepared statement of Dr. Batra follows:]

Testimony – Romilla Batra, MD., M.B.A., SCAN Health Plan**Hearing: Public Health Data and Social and Determinants of Health
The Subcommittee on Health of the Committee on Energy and Commerce
United States House of Representatives
June 24, 2021**

Good morning Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Health Subcommittee. My name is Romilla Batra, MD., M.B.A, and I am the Chief Medical Officer at SCAN Health Plan and a primary care physician. Thank you for the opportunity to share how SCAN addresses Social Determinants of Health (SDOH). It is a great honor to be here today.

My remarks will briefly cover SCAN's background and history with SDOH, SCAN's approach to addressing SDOH, supplemental benefits, and recommendations. SCAN serves mainly older adults, so my comments will focus on this population.

I. SCAN Background/History with SDOH

SCAN Health Plan is one of the nation's largest not-for-profit Medicare Advantage (MA) plans, serving more than 220,000 Medicare beneficiaries in California. Since its founding in 1977, SCAN has been a mission-driven organization dedicated to keeping seniors healthy and independent. For the past four years, SCAN has received a 4.5 (out of 5-Star-Rating) from the Centers for Medicare & Medicaid Services.

SCAN, which stands for Senior Care Action Network, began in Long Beach, California by 12 angry seniors who wanted not only medical care, but also social services to help them remain living in the community. In 1985, SCAN received a national social health maintenance organization contract and participated in a congressionally mandated demonstration to provide home and community-based services to medically complex patients at risk of nursing home placement. SCAN remained in the demonstration until it ended in 2005 and transitioned into a Medicare Advantage Prescription Drug Plan (MA-PD). SCAN continues to specialize in serving frail, older adults. We offer a variety of Special Needs Plans (SNPs), including the only Fully Integrated Dual Eligible (FIDE) SNP in California.

SCAN also operates Independence at Home (IAH), a separate community-based organization that provides services to meet the social, functional, and medical needs of community dwelling older adults, regardless of their health plan membership. It also offers a multipurpose senior services program to nursing home eligible older adults, education programs, community funding, volunteer opportunities, and other community services throughout our California service area.

II. The Importance of Addressing SDOH

Addressing SDOH (e.g., food insecurity, housing, social support, caregiver support, isolation, transportation, community safety, etc.) is important to improve health outcomes as these factors represent 70 percent of the drivers affecting a person's overall health status.¹ A 2019 nationally representative survey found that 53 percent of the over 2,000 respondents reported being adversely affected by at least one unmet social need. Not surprisingly, individuals with unmet SDOH needs generally have higher medical utilization and poorer health outcomes.²

III. SCAN's Approach

SCAN's approach to addressing SDOH needs is systematic, person-centered, and grounded in serving diverse populations in an equitable manner. It includes the following steps:

- **Identify** social risk factors that affect health outcomes using multiple data sources from SCAN and provider group (if applicable);
- **Stratify** members/clients based on clinical risk and unmet social needs;
- **Serve** members/clients through one or more of SCAN's suite of SDOH programs or benefits;
- **Measure** impact of SDOH programs on members/clients' health outcomes through ongoing tracking and analysis and adjust accordingly;
- **Scale** programs/services to a broader population, as appropriate; ideally performed in a cost-effective manner; and
- **Engage and support** community resources and stakeholders and promote community partnerships to ensure that care and services address what matters most and reflects the needs of our members, clients, and the community.

The following provides additional background on the above steps:

- **Identify.** A key component of how SCAN identifies members' health needs is through our Health Risk Assessments (HRA). All SCAN members receive a HRA, which gathers data on: 1) Health Behavior and Status, 2) Demographics, and 3) Social Determinants of Health. It includes several questions on SDOH and basic needs, such as housing, language and literacy, medical needs, food, transportation, social connectedness, and isolation. Since 2018, approximately 80,000 of SCAN members have completed a HRA, which is about a 35 percent response rate. For our SNP members, the HRA completion rate is 80 percent.

SCAN also uses other data sources to help identify members' health needs including population-level data, such as the social vulnerability index; medication data; lab data; and encounter data.

¹ 2012 Bipartisan Policy Center Report: Lots to Lose: How America's Health and Obesity Crisis Threatens our Economic Future

² McKinsey 2019 Consumer Social Determinants of Health Survey

- **Stratify/Serve.** After collecting members' SDOH data, SCAN stratifies the information based on clinical risk and unmet social needs. This allows us to direct people to appropriate programs for assistance.³ The following are three examples:
 - Member-to-Member Program. Seniors (who are also SCAN Health Plan members) are trained in motivational interviewing, so that they can communicate peer-to-peer with individuals who are at high-risk for geriatric conditions and areas of concern, including incontinence, mental health issues, falls, and low physical activity. The goal of this outreach is to encourage individuals to be more engaged in their healthcare and open to discussing these topics with their physician. SCAN contacts about 10,000 members per year, and we have a 51 percent adoption rate (members who choose to participate).
 - Personal Assistance Line (PALS) Program. SCAN dual eligible members are assigned their own assistant or PAL. The PAL onboards the new member, conducts a health risk assessment to screen for health and SDOH needs, and connects the member to health plan benefits and community resources. Because approximately 40 percent of our duals population are Hispanic, all of our PALs are linguistically and culturally competent to serve our members.
 - Connecting Provider to Home (CP2H). The CP2H program assists our extremely high-risk members with complex social and medical issues. Members receive in-person intensive case management led by a social worker, community health worker, and a medical provider team. The CP2H team visit members to identify non-medical needs such as housing insecurity, social isolation and nutrition; assist them in obtaining needed resources; and provide insight to the medical care team during appointments. SCAN evaluated the CP2H program prior to the pandemic with a "control" and "intervention" population. Results showed reductions in hospitalizations and emergency room visits following CP2H interventions. In both cases, the results were statistically meaningful.

CP2H - SCAN Member Story

Mr. M lives alone in a mobile home and, at the time of his enrollment in the SCAN CP2H program, he was grieving the loss of his spouse. The CP2H team went to his home and completed a thorough review of his living situation, including his ability to afford food, shelter, as well as his health needs.

³ SCAN/IAH also pilots programs based on older adults' health needs, such as the Insights program, which provides at home, no-fee, evidence-based mental health care in clients' primary languages (211 clients participated). Results showed significant improvements in depression, anxiety, quality of life, self-rated disability, and patient activation. <https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16088>

- **Assessment.** Based on the assessment, the team concluded that Mr. M. had poor access to nutritious food and was struggling to pay for food and utilities. He had a history of falls and multiple serious chronic conditions, including chronic kidney disease (stage 4 and approaching dialysis), hypertension, congestive heart failure, and depression. He was also dealing with incontinence. Because of his financial situation, he had trouble adhering to medications. Although he had a primary care physician, Mr. M was not engaged in managing his health and other social issues.
 - **Intervention.** The CP2H team identified the benefits Mr. M. could access to support his health. They also contacted his physician to identify a solution to support balance and prevent falls in his mobile home; equipped him with an ongoing delivery of incontinent supplies; and identified community resources for food and utility assistance and enrolled him in the programs.
 - **Outcome.** Today, with the support of the CP2H program and team, Mr. M is able to afford nutritious foods, utilities, and medications. He is managing his incontinence, chronic conditions, and has not fallen. The CP2H team continues to check on Mr. M periodically.
- **Measure/Scale.** SCAN continually measures health outcomes and uses data to improve care when necessary. We also measure the adoption of newer benefits introduced to address social needs, such as caregiver respite programs. Two examples of developing new interventions based on the results of our data are our medication adherence and flu vaccination efforts.

SCAN analyzed our members' medication adherence rates against our star ratings through a health equity lens (we have data on race and ethnicity for about 90 percent of our members) and discovered that our Black and Hispanic members scored lower than our White members did. We then developed a targeted medication adherence program for our Black and Hispanic members.

In addition, SCAN developed a specific intervention for flu vaccination for Spanish-speaking populations, which has increased vaccination rates. SCAN's COVID-19 vaccination efforts also produced positive results, especially in the Black and Hispanic communities. SCAN helped close the health equity gap by reducing vaccination rates among our Black versus White members from 17 to 6 percent and from 11 to 4 percent for our Hispanic versus White members.

- **Engage/Support.** SCAN connects our members with community resources and strengthens community capacity by providing grants to local organizations in areas that

serve SCAN members. During COVID-19, SCAN's IAH program gave \$1.8 million to community-based organizations to help them respond to the increased demand for their services. SCAN also has Community Based Organization Advisory Committee, which fosters connections and builds strong partnerships with community organizations.

IV. Supplemental Benefits

Another important tool for addressing SDOH is MA plans' ability to offer supplemental benefits. Over the years, SCAN has offered many supplemental benefits to our members that have greatly improved their quality of life. These include hearing aids, eye exams and glasses, dental care, fitness, meals, transportation, in-home support, bathroom safety, telemonitoring, and caregiver support.

Below are two examples of how supplemental benefits are helping SCAN members.

- **Fitness Benefit.** A Kaiser Health News article featured an 87-year old male SCAN member who is using our fitness benefit.⁴ Below is a description of his progress.

When we first talked, his AFib had slowed him down so much he could not walk a block without getting winded. He wanted to do more so we started out with baby steps. He agreed to get a FitBit, try to walk two blocks, get up every hour to walk around the house, and go to silversneakers.com to find easy sitting and standing exercises.

[Now] he is averaging 5000 steps/day and his personal best so far is just over 8000 steps. His goal is to reach 10,000 steps. He now takes his dog for a walk 3-4 times a week. When his nearby Silver Sneakers gym reopens, he and his friends are planning on returning.

- **Transportation.** When we asked our members, as part of the HRA, if they would use the transportation benefit, all cohorts (members divided from low to very high need) responded they would use it. The transportation benefit was especially relevant to our most frail members with complex health conditions.

SCAN is grateful to Congress for allowing greater flexibility to offer supplemental benefits to people with chronic conditions.⁵ Since 2019, SCAN has been able offer additional targeted benefits to help our members. Examples of SCAN's new supplemental benefits include:

- **Returning to Home** provides personal in-home care (40 hours total per year) to help members after a hospitalization with activities of daily living such as bathing, dressing,

⁴ <https://khn.org/news/article/as-pandemic-eases-many-seniors-have-lost-strength-may-need-rehabilitative-services/>

⁵ Providing additional supplemental benefits for chronic care conditions were included in the Bipartisan Budget Act of 2018. Beginning in 2020, MA plans could target non-medical health-related services to members who have chronic care conditions.

laundry, bed linen changing, light housekeeping, caregiver relief, etc. It also provides telephone coordination aid in scheduling follow-up care and up to four weeks of meals delivered to the home;

- **Home Advantage** provides a licensed Occupational Therapist who conducts an initial in-home assessment, identifies risk for falls/injury, and recommends safety measures to keep people safe at home. A SCAN Care Navigator conducts a follow-up home visit to help facilitate the home safety plan;
- **Non-Medical Transportation** allows members to use a portion of their routine transportation rides to go to the senior center, grocery store, and fitness center.
- **Respite Care** provides up to 40 hours of respite care to relieve full-time informal caregivers.
- **Chronic Condition Meals** provide nutritious meals to eligible members who have one or more chronic conditions. Members receive three packaged meals per day that support the special dietary needs of their condition, for up to 28 days.
- **HEALTHtech** provides a technology support line that helps members use a computer, tablet, or smartphone to access healthcare and health-related information and services.
- **BrainHQ** provides online exercises at no cost to enhance memory, brain speed, and other functions to boost brain health.
- **Telehealth** offers zero copays for virtual physician visits.

We are still evaluating the outcomes of our latest supplemental benefits, but are already seeing promising results. Based on the small surveys we conducted, there is a reduction in utilization following the Returning to Home benefit and the Home Advantage program.

V. Recommendations

As a nonprofit MA plan with a long history of serving older adults and vulnerable populations, we know first-hand how supplemental benefits improve the lives of our members. We respectfully ask Congress to continue allowing MA plans to offer flexible benefits and consider extending them to additional populations in the future, such as people who are experiencing homelessness.⁶

We also recommend that Congress include SDOH, such as food insecurity, to the criteria for supplemental benefits more broadly than only for specific chronic conditions. This would help to mitigate some social inequities and allow health plans to expand services to more members in need.

Finally, we recommend that you consider supporting, *H.R. 2166, Ensuring Parity in MA/PACE for Audio Only-Telehealth Act*. This bill would create parity between the audio/video platforms for risk adjustment purposes. We discovered during the pandemic that many older adults do not

⁶ In July 2019, SCAN launched a Housing and Homelessness Care Management Initiative that focuses on collaborating with providers and community-based organizations to provide long-term complex case management to homeless or at risk members. This program provides social supports to the members with a special focus on getting the member housed or helping the member keep their current housing.

have access to video technology because they cannot afford it or do not have broadband service. There is also a Senate companion bill, *S. 150, Ensuring Parity in MA for Audio Only-Telehealth Act*.

On behalf of SCAN, thank you for your ongoing commitment to improving healthcare for older Americans. We would welcome the opportunity to be a resource to members of this committee if we can be of service. Thank you again for the honor to speak before this distinguished committee. I look forward to your questions.

Ms. ESHOO. Thank you. Thank you, Dr. Batra.

I think that it would be really helpful if the witnesses—because this is a legislative hearing—and with the extraordinary experience and background that you all have, if you could weave into your comments if you think we are hitting the mark with any one of these bills. Any suggestions, critiques, comments about them, I think, would be most helpful to the members of this subcommittee.

Next, Ms. Blauer, it is a pleasure to welcome you again. Thank you. And you are recognized for your 5 minutes of testimony.

STATEMENT OF BETH I. BLAUER

Ms. BLAUER. Thank you very much, Chairman Eshoo, Ranking Member Guthrie, and members of the subcommittee. Thank you for inviting me to participate in today's hearing and for dedicating your time to an examination of the role of data and health outcomes.

My first job in the public sector was nearly two decades ago, when I worked as a juvenile probation officer for the State of Maryland. I left the State after leading an ambitious, cross-government data initiative that was credited with significant outcomes for residents, ranging from market reductions in infant mortality, nation-leading school performance, and record low crime rates. Since 2015 I have led a center at Johns Hopkins University focused on building the capacity of local leaders to use data to improve outcomes. And for the last 17 months, I have been the data lead for the Johns Hopkins University Coronavirus Resource Center. I have seen the very best and the very worst of data use.

The bills that are the subject of today's hearings go a long way to realign Federal resources with interventions that are proven, measurable, and focused on ending multigenerational health and well-being disparities.

In the last 18 months, governments at all levels did something incredibly remarkable. They built data collection efforts, shared data, and made real-time decisions based on near-time data. Never before has the Nation endeavored to realize a coordinated effort around data sharing, data-informed decision making, and collective outcome measurement at such scale. Local and State governments used every possible lever to stall the spread of this disease, including the very difficult decisions of closing businesses and schools.

What has this last year taught us about using data to collectively solve problems? At the Johns Hopkins Coronavirus Resource Center, we became a trusted resource for millions of viewers worldwide. Over the course of weeks, JHU developed a methodology for scraping public data and encouraged State and local governments to share their data in standardized ways. JHU data scientists set up an internal governance and articulated standard collection methods under the guidance of public health and medical experts. We openly shared the entire process with the public.

By January 2021 we had accrued more than a billion views. Our audience included news outlets, local governments, and everyday people that were making deeply personal decisions about how they would navigate their public lives. The backdrop to our entire pandemic experience was and continues to be a hunger for sound, publicly available data.

This Congress has an opportunity to capitalize on the public demand for data, the financial investments we have already made in data infrastructure, and the newly minted analytic skill that has emerged across government during COVID-19, and improve upon the systems to provide accountability, accessibility, consistency, equity, and sustainability. But there are some lessons that I can offer that have been helpful over the course of my public-sector career.

First, we need data standards. The first instinct when you consider strengthening a data practice is to think about IT modernization or tools. But the truth is, one of the most important elements of a strong data practice is actually in the governance and the alignment of creating a common language and rules around how and why data is collected and applied to problem solving. This will not be solved by one agency. This is an interagency dilemma that requires a centralized administrative focus.

Second, we must invest in better demographic data collection. State and Federal demographic data does not align. Inconsistencies and categorization between States, and even within States, make data incomparable and can obfuscate the disproportionate effects that the pandemic—and, in reality, all programs—targeted, entrenched social determinants of health have had on people of color. Without standards there is no way to analyze available data to locate vulnerable populations, and appropriately intervene.

Finally, whenever possible, we must make data public. While I applaud that many of these bills require data collection in a manner that is anonymized, disaggregated, and stratified, they do not at all provide a plan for public dissemination. These data will be high quality, high resolution, and in high demand.

Government will not be able to turn the tide on social determinants of health alone. It will require deep coordination and public engagement in the most intimate of ways. Our centers at JHU continue to work to build the capacity of local leaders to use more data as they examine their practice, and architect on-the-ground strategies to deliver better outcomes for people. But they need the support of our partners within the Federal Government to have the greatest impact.

I am so thankful to be included in the hearing today, and I look forward to fielding any questions. Thank you.

[The prepared statement of Ms. Blauer follows:]

**Testimony for the Record
Submitted to the House Committee on Energy and Commerce
Subcommittee on Health for the Hearing
“Empowered by Data: Legislation to Advance Equity and Public Health”**

June 24, 2021

Beth I. Blauer, J.D.
Associate Vice Provost for Public Sector Innovation
Johns Hopkins University

Chairwoman Eshoo, Ranking Member Guthrie and members of the Subcommittee, thank you for inviting me to participate in today’s hearing and for dedicating your time to an examination of the role of data in health outcomes and the capacity of data to assist in the dismantling of entrenched structural racism.

For the last six years I have led a center at Johns Hopkins University (JHU) focused on building the capacity of local leaders to use data to improve outcomes. For the last 17 months, I have been the data lead for Johns Hopkins University’s Coronavirus Resource Center. I have seen the very best and the very worst of data use. I am pleased that this Congress is recognizing the role of data not only in improving outcomes but also in contributing to health disparities and their devastating outcomes. The bills that are the subject of today’s hearing go a long way to realign federal resources with interventions that are proven, measurable, and focused on ending multigenerational health and wellbeing disparities.

To begin, we must acknowledge the role data has played in exacerbating health disparities and invest in data collection methods to prevent further widening of gaps. Whether it’s the historic use of data to create redlined maps to determine where we deploy community-based resources, or inadvertently incentivizing counterproductive policing behavior to produce better metrics/outputs, data has a complicated history in the public sector, at best. I am honored to be here today to describe how the Center advises policymakers at the local, state and national levels to use these same tools to dismantle the systems and the approaches that have created current disparities and improve government performance.

COVID-19 Tracking at JHU

Take COVID-19 data reporting, for example. In the last 18 months, government at all levels from municipalities to federal agencies, did something incredibly remarkable. These governments built data collection efforts, shared data, and made real time decisions that were based on near time data. Never before has the nation endeavored to realize a coordinated effort around data sharing, data informed decision making, and collective outcome measurement at such scale. Local and state governments quickly built a capacity for looking at data around the clock, deploying resources throughout their communities, measuring the effects of their

interventions, using every possible lever to stall the spread of this disease including closing businesses and schools.

These efforts were not without their challenges. States scrambled to understand how to define data, how to share data with the public, and how to communicate policy decisions that were based in data. The confusion that quickly surrounded these efforts was due in large part to a lack of unified data collection and reporting standards. The result? Many States defined Covid cases, deaths, and testing differently and these definitional variances made comparing conditions difficult, made fluid borders confusing, and made policies difficult to enforce. As difficult as this effort was, imagine if we didn't have real time access to this data. Imagine if we accepted a years-long delay getting this data and responding to this devastating virus?

So, what has this last year plus taught us about using data to collectively solve problems?

At the start of 2020, Johns Hopkins launched the Coronavirus Resource Center, which quickly became a trusted resource for millions of viewers worldwide. International health organizations, the federal government, and institutional leaders faced challenges in mobilizing to get data collected or shared given the unprecedented circumstances. Early in 2020, an interdisciplinary group of researchers at JHU began to manually collect international health data that was often released in unstructured formats, press releases, public announcements and government dashboards. Over the course of weeks, JHU developed a methodology for scraping public data and encouraged state and local governments to share their data in standardized formats. JHU data scientists set up internal governance and created definitions with the help of public health and medical experts. Our team articulated standard collection methodologies and openly shared this process with the public. At first, we built data visualizations for fellow researchers but quickly learned that the public was urgently looking to source this data, as well.

By mid-April of 2020 we had millions of viewers visiting our site every day and by January 2021, we had accrued more than a billion views. Our audience included news outlets, local governments, and everyday people that were making deeply personal decisions about how they would navigate their public lives. Families all of a sudden faced with weighing the safety of going to the grocery store or sending children back to school needed reliable, understandable and localized information. The backdrop to our entire pandemic experience was and continues to be a hunger for sound, publicly-available data. Now imagine if we had access to the same level of data but about the health of our communities, the quality of our air, the safety of our communities, the social determinants of our health? Not data that takes more than a year to process like our current collection methods for the very comorbidities that complicated pandemic response. Not data that is only collected for the purposes of reporting on big block grants, but the type of data that can help policymakers immediately invest in interventions that work, in the places that need those investments the most. The type of data that can immediately be used to retire broken systems and help reallocate scarce resources to systems that are proven to be effective.

This Congress has an opportunity to capitalize on this public demand for data, the financial investment in data infrastructure and the newly minted analytic skill that has emerged during the COVID-19 pandemic and improve upon the systems to provide accountability, accessibility, consistency, equity, and sustainability. The bills under review today are an encouraging step in this direction.

The data provided by local, state and national COVID-19 dashboards have led to major policy decisions across all levels of government and influenced the behavior and decisions of many Americans. The average American can now access COVID data, investigate hotspots, find information about vaccination locations and infection rates, and browse pertinent articles directed at the lay public. Due in large part to these efforts, test positivity rates are now dramatically decreasing across the country. While lower infection rates in nearly every State are cause for measured optimism, it is crucial that we maintain the infrastructure developed during the pandemic, both to monitor the continued spread of COVID-19 and to leverage in the fight against the many public and social health crises that our communities face. The Federal government can encourage growth in these collection efforts and reverse the concerning trend of divestment in data infrastructure that has begun in more than half of the states in this country.

We Need Data Standards

Pandemic data collection is not flawless and our national data strategy could be improved through data standardization. The pandemic revealed that the systems that feed these dashboards are underdeveloped and often arduous. Across the many agencies of the federal government there is no one common language to help ease the often-confusing process of collecting program level data. Definitions vary in the simplest of terms, multiple agencies with different ways of collecting addresses, enrollment, the definition of recipient or household variables that make understanding conditions in our communities particularly challenging. This will not be solved by one agency, this is an interagency dilemma that requires a centralized administrative focus. COVID-19 data collection again proves illustrative in this context.

We know federal data standards work when they are established. Hospitalization data has some of the best temporal and geographic resolutions in the realm of COVID-19 data due to standardized data reporting methods mandated by the Centers for Medicare & Medicaid Services. The U.S. Department of Health and Human Services releases the hospitalization data it receives from the states daily. This daily reporting of data allowed for early identification of the shift in trends before the COVID-19 resurgence in the Spring. This equipped local leaders to enact new policies to curb the rise in cases, and to request aid from the federal government. This is one of the only cases where federal standards were established for pandemic data, and they work well for the purposes of governance and decision making, but the standards were not well planned, were rolled out with confusing guidance and added additional burden to already strapped health systems.

Today you are discussing H.R. 976, the "Ensuring Transparent Honest Information on COVID-19 Act." This bill would require States to provide many critical data on either a daily or weekly basis. The consistency across States established by the ETHIC Act would allow data scientists to perform in-depth analyses on COVID-19 spread, the efficacy of policy measures and shutdowns, disease resurgence, and much more. This bill could be strengthened by requiring public health data reporting for States moving forward as we have now seen the potential opportunity for near time health data collection and the damage when public health data is not standardized, centralized, and consistently updated.

Without federal mandates, States are now beginning to reduce their data collection efforts and reporting cadences. As of this writing, 32 States and territories were no longer providing COVID-19 data updates every single day as they previously did. Delays in reporting updated public health data could result in delayed identification of resurgence and variants, limiting the potential response of the federal government. The ability of the government to rapidly respond to everchanging data during this pandemic has saved countless lives, and we should aggressively take advantage of this infrastructure, deepen the data skills of program leaders, and begin to widen our regular data collection efforts to align to the important business of measuring public health writ large.

Some states have argued that dashboards are no longer necessary since the CDC tracks pandemic data. While the CDC does aggregate COVID-19 data, it is important to note that the CDC is limited to using data filed through official reporting channels, which are not publicly available and often tied to regulatory frameworks that are not conducive to real-time response. This can result in a serious reporting lag as well as data discrepancies when State updates are out of sync with official federal channels. While the CDC has been an invaluable leader and resource throughout the pandemic, this does highlight the need for robust data collection and reporting systems at the local and state levels to better inform and give context to federal data reported by the CDC. This is not the time to slow data collection and reporting; instead, we must solidify and unify data systems to end COVID-19, address the multifaceted challenges of public health our communities were facing in pre pandemic times, and prepare for the next public health crisis.

Data standards and a strong cross government data governance approach would be welcomed by local leaders. Over the course of this pandemic, we at JHU have been in constant communication with Governors and Mayors, and health departments as they have navigated their role in data collection, data use and data sharing. Leaders at all levels were desperate for guidance on everything with simple definitions to positivity calculations. Enforcing data standards would be a welcome challenge to the leaders in our country who have unleashed the power of data use in their communities to good effect.

Demographic Data is in Disarray

State and federal demographic data does not align. State reports to the CDC do not always match the state-reported data on their own dashboards. Inconsistencies in categorization between states make data incomparable and can obfuscate the disproportionate effects that the pandemic has had on people of color. Some states even lack standardization within their own health departments, using different demographic categories between testing data and vaccination data. Without standards there is no way to analyze available data to locate vulnerable populations. Our current system does not allow for simple analyses such as determining whether black people or white people are more likely to die from COVID-19 or have access to life saving vaccines.

Local politicians have been tasked with protecting their citizens, but they are not equipped with the complete datasets they desperately need to make critical decisions. Due to inconsistencies and lack of communication between local municipalities, states, and the federal government, local leaders are forced to make decisions without the full power of data behind them, which is unacceptable during a public health crisis but should always be unacceptable. As of now, local leaders can only design targeted outreach strategies by guessing where hotspots of unvaccinated individuals exist through comparisons of incomplete demographic data on people vaccinated with census-level population data.

Additionally, the lack of comprehensive demographic data cloaks the disproportionate impact the virus is inflicting on minority communities and prevents local leaders from designing relief programs. This dynamic is not unique to COVID. States often only provide demographic data in an aggregated form, preventing local governments and the public from accessing detailed demographic information for their areas. This information would inform policy decisions of city and county leaders by more accurately identifying hotspots, opportunities to invest in public health assets, and track disease outbreaks in near real-time. The data can and should be publicly available, disaggregated, randomized, individualized, and anonymized, so that policymakers and the public can make safe, informed decisions and identify immediate risks.

Make the Data Public

Data collected by the government and funded by the taxpayers should be public. While I applaud that many of these bills require data collection in a manner that is anonymized, disaggregated, and stratified by race, ethnicity, age, sex, geographic region, they do not all provide a plan for public dissemination of the data. These data will be high-quality, high-resolution, versatile tools for research, public health planning and pandemic preparedness.

The JHU COVID efforts were purposefully public in every possible way. We have learned the value of opening up data to the public. Obviously not everyone will use raw data, but often local views of the data help identify hidden clues that can unlock stronger and healthier communities. Mayors and county administrators have relied on the public release of data to get a better sense of the impact the pandemic is having on their communities. The complete lack of intergovernmental data sharing agreements deepened local leaders' dependence on public

data. Just as money follows the well-worn paths of the large block grant programs from the federal government to individuals, so should the data. Data on who is most in need, insights on the efficacy of best practice, and the outcomes programs were designed to achieve. Data, in compliance with privacy protections afforded in our laws, should be shared with policy makers and with the public to build trust, to change our behavior and to incentivize participation in the solutions we seek.

Government will not be able to turn the tide on the social determinants of health alone, it requires deep coordination with government at all levels and public engagement in the most intimate of ways. Our center at JHU continues to work to build the capacity of local leaders to use more data as they examine their own practices and architect on the ground strategies to deliver better outcomes for people. Our communities can see the difference and the pandemic is another example of how government data shaped our outcomes. Over the last year we wore our masks, we stayed home, we sacrificed, and now we are beginning to recover. Imagine if we applied the same level of focus to the generational challenges our communities have endured for far too long.

I would now be pleased to take any questions you may have.

The opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University.

Ms. ESHOO. Well, we are very thankful to you. Your testimony was highly instructive.

Next it is a pleasure to once again welcome and thank Dr. Faisel Syed for—and you are now recognized for your 5 minutes of testimony.

STATEMENT OF FAISEL SYED, M.D.

Dr. SYED. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and members of the subcommittee. I am Dr. Faisel Syed, and I am honored to testify on behalf of America's Physician Groups.

APG is a national professional organization that represents over 300 physician groups and 195,000 physicians who provide care to nearly 45 million patients. APG member organizations share a vision to transition from a fee-for-service system to a value-based system, where physician groups are accountable for the cost and quality of care.

I always wanted to be a doctor. I was appalled that people died because they had no access to medical care. I joined one of the largest FQHCs in the country because they treated everyone the same, regardless of their ability to pay. Today I am the national director of primary care for ChenMed. We are a fully capitated primary care practice for senior citizens. But I am also a son. And today's hearing is about my dad.

Dad was an inventor, but then he got sick: heart disease, diabetes, chronic low back pain, and memory loss. Dad saw five specialists but not a PCP. None of them spoke with each other. Dad was taking pills for side effects from other pills. I convinced him to sign up for a Medicare Advantage plan, where a PCP would coordinate his care. Today Dad's heart function is normal, his diabetes is under control, his back pain and memory loss are gone, and he is on very few meds. So when we talk about Medicare Advantage, I think about Dad and people in this country like him, who are older and medically complex.

My patients are over 70 years old, suffer from 5 or more chronic medical conditions, and live on fixed incomes. These people fought in wars and marched for civil rights. Today they are some of the most underserved in America.

We claim to have the world's best healthcare system, and if you have money, the care you get is remarkable. But the color of your skin, the balance in your bank account, and the diploma hanging on your wall have more to do with staying healthy than pathophysiology. We cannot improve healthcare for everyone if the access to healthcare or healthy lifestyles are beyond someone's means. Low-income and minority populations in the United States don't live as long as more affluent Americans. There are ZIP Codes in New Orleans where life expectancy is only 54 years old. In more affluent ZIP Codes a few miles away, life expectancy is close to 80.

Medicare Advantage is the great equalizer and plays an instrumental role in the transformation of our Nation's healthcare system. It rewards physicians who participate in high-risk contracts for the value of their services. The Medicare Advantage value-based payment arrangement creates three distinct advantages: a team-based primary care delivery system; incentives for delivering

primary care in the right setting; and a holistic approach that addresses the patient's mental health, behavioral health, and home environment needs. Medicare Advantage acknowledges that 70 percent of medical outcomes are based on patient lifestyle.

I can offer tailored solutions to people with food and housing insecurities, health literacy, and transportation issues. Because we are fully capitated, I can focus on prevention and early intervention. I invest the time it takes to build trust and influence patient behavior. Thanks to Medicare Advantage, I can offer exercise classes to patients who are afraid to take a walk through their neighborhoods, on-site medication pickup to patients who have no way to get to a pharmacy, social services to help patients eat healthier. And I can see patients as often as needed to prevent little problems from becoming big ones.

I had a patient once who was an uncontrolled diabetic. He refused to take insulin. Medicare Advantage gave me the time to get to know him. He told me about living on a fixed income and not having enough money to buy groceries. I earned his trust. He drank six to nine sodas every day. I made a deal with him. I wouldn't bug him about the insulin if he cut back on the soda. I suggested he drink seltzer with artificial sweetener. It turns out he liked the fizz more than the soda. Within a few months we got his blood sugar under control without a single shot of insulin. That is the beauty of Medicare Advantage.

At ChenMed we practice a high-touch preventative model. Our patients have 35 percent fewer emergency room visits and 51 percent fewer hospitalizations than the average Medicare beneficiary. We did a survey, and 94 percent of our patients said they were highly satisfied with the care they received. Our model fulfills the promise of Medicare Advantage and restores the sacred doctor-patient relationship. Let's prioritize what is working and make it better. Thank you.

[The prepared statement of Dr. Syed follows:]



Testimony of Faisel Syed, MD
House Committee on Energy and Commerce

June 24, 2021

Good morning Chairwoman Eshoo, Ranking Member Guthrie, and other members of the subcommittee. My name is Dr. Faisel Syed and I currently serve as the National Director of Primary Care for ChenMed. I am honored to testify today on behalf of America's Physician Groups. APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care to nearly 45 million patients. It is the vision of APG's member organizations to transition from the fee-for-service (FFS) reimbursement system to a value-based system where physician groups are held accountable for the cost and quality of care they provide to their patients. APG's preferred model of capitated, delegated, and coordinated care, eliminates incentives for waste associated with FFS reimbursement.

As a young man growing up, I always wanted to be a doctor. I was appalled that people died because they had no access to medical care. I joined one of the largest federally qualified health centers (FQHC) in the country because they treated everyone the same, regardless of their ability to pay. I now work at ChenMed, a fully capitated primary care practice for senior citizens and as a physician, it is my utmost concern to make sure that every elderly patient I see receives the best treatment possible. But I am also a son, and I would like to take this opportunity at today's hearing to speak about my dad. He was an inventor, but then he got sick. Dad suffered from multiple chronic diseases including heart disease, diabetes, chronic lower back pain, and memory loss. Dad saw five specialists but not a primary care physician (PCP). None of them spoke with each other. Dad was taking pills for side effects from other pills.

I convinced him to sign up for a Medicare Advantage (MA) plan where a PCP would coordinate his care. Today, Dad's heart function is normal, his diabetes is under control, his back pain and memory loss are gone, and he is on very few meds. So, when we talk about MA, I think about Dad, and people in this country like him who are older and medically complex. My patients are over 70 years old, suffer from 5 or more chronic medical conditions, and live on fixed incomes. These people fought in wars and marched for civil rights. Today, they are some of the most underserved in America.

We claim to have the world's best healthcare system; and if you have money, the care that you receive is remarkable. But the color of your skin, the balance in your bank account, and the diploma hanging on your wall have more to do with staying healthy than pathophysiology. We cannot improve healthcare for everyone if the access to healthcare, or healthy lifestyles, are beyond someone's means. Low-income and minority populations in the United States don't live

as long as more affluent Americans. There are zip codes in New Orleans where life expectancy is only 54 years old. In more affluent zip codes a few miles away, life expectancy is close to 80. Many of the seniors whom we treat at ChenMed live on fixed incomes which can lead to issues such as food insecurity, poor nutritional habits, the inability to purchase personal care items, and other health issues.

Medicare Advantage is the great equalizer and plays an instrumental role in the transformation of our nation's healthcare system away from paying for the volume of services and toward rewarding physicians, particularly those participating in high risk MA contracts, for the value of the services that they provide. MA provides higher quality care for seniors and the value-based payment arrangements within MA create three key incentives: (1) a team-based approach that emphasizes primary care; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) a care team that addresses the patient's total care needs, including mental health, behavioral health, and home environment. The third point is critical; MA also acknowledges that 70 percent of medical outcomes are based on patient lifestyle. Through MA, I am able to offer tailored solutions to people with food and housing insecurities, health literacy and transportation issues. Because we are fully capitated, I can focus on prevention and early intervention. I can invest the time it takes to build trust and influence patient behavior. Thanks to Medicare Advantage, I can access services others cannot. I can offer exercise classes to patients who are afraid to take a walk through their neighborhoods. I can offer on-site medication pickup to patients who have no way to get to a pharmacy. I can offer social services to help patients eat healthier. And I can see patients as often as needed to prevent little problems from becoming big ones.

One previous patient that I treated was an uncontrolled diabetic who refused to take their insulin as prescribed. MA gave me the time to get to know him. He told me about living on a fixed income and not having enough money to buy groceries. I earned his trust. He told me he drank 6-9 sodas every day. I made a deal with him; I wouldn't bug him about the insulin if, in turn, he would cut back on the soda. I suggested he switch to drinking seltzer with artificial sweetener. As it turned out, he liked the fizz more than the soda! Within a few months, we got his blood sugar under control without a single shot of insulin. That's the beauty of MA.

At ChenMed, we practice a high-touch, preventive model. Our patients have 35 percent fewer emergency room visits, and 51 percent fewer hospitalizations than the average Medicare beneficiary. We conducted a survey and 94 percent of our patients said they were highly satisfied with the care they received from their clinician. Our success validates Medicare Advantage. The capitated platform restores the sacred doctor/patient relationship. It enables us to take full responsibility for the health of our patients. Let's prioritize what's working and make it better.

Ms. ESHOO. Thank you, Doctor. Maybe it will come up during the questions from Members, but I want to remind the witnesses that this hearing is about public health agencies in the country. It is wonderful to hear about how wonderful Medicare Advantage is, but we have 13 bills that we are examining in this legislative hearing today, so I hope that those that are not speaking to those, that your experience will be probed by Members as to what is before us, and that is the 13 bills that we are examining today, to see if we are on the mark or off the mark, and if we can do better, and what is missing, and all of that.

So it is a pleasure to recognize Dr. Kara Odom Walker, and you are recognized for your 5 minutes of testimony. And thank you again for being willing to be a witness.

STATEMENT OF KARA ODOM WALKER, M.D.

Dr. WALKER. Thank you so much. Good morning, everyone, and Chairwoman Eshoo, Chairman Pallone, Ranking Members McMorris Rodgers and Guthrie, and distinguished members of the committee. My name is Dr. Kara Odom Walker, and I am executive vice president and chief population health officer at Nemours Children's Health, and I am honored to testify to get—today, and hope to speak to some of those questions.

Nemours is one of the Nation's largest and—pediatric health systems, including 2 freestanding children's hospitals and a network of nearly 80 primary and specialty care practices across 5 States. We seek to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care while also caring for the health of the whole child beyond medicine.

Decades of research demonstrate that substantially reducing disparities requires a multigenerational approach, starting in the early years of a child's life, and with the help of the mother. We know that children who live in the most economically disadvantaged counties in America die at rates up to 5 times those of their peers in the—and are 3 times more likely to lack regular access to healthy food—times more likely to drop out of high school.

If effectively implemented and designed in consultation with those they intend to serve, numerous policy approaches can substantially reduce disparities and improve health. Nemours is appreciative that the subcommittee is considering legislation to advance these aims.

Nemours supports the Caring for Social Determinants of Health Act and commends Congresswoman Lisa Blunt Rochester and Congressman Gus Bilirakis for introducing this bill. It would require the Secretary of Health and Human Services to update guidance to State health officials regarding strategies to address social determinants of health in Medicaid and CHIP. This bill would ensure that, as new bright spots and approaches emerge, they are disseminated to States to spread what works.

Nemours also appreciates the subcommittee's consideration of the Quit Because of COVID-19 Act introduced by Congresswoman Lisa Blunt Rochester and Congressman Brian Fitzpatrick. This bill would expand coverage of comprehensive tobacco cessation services for individuals—Medicaid and CHIP. One of the many benefits of increased access to cessation services and decreased tobacco use is

the potential for reduced secondhand smoke exposure in infants and children. This would also help address disparities. Despite similar or lower smoking rates compared to other racial and ethnic groups, African Americans have the highest rates of tobacco-related cancer and are more likely to die from the disease. As a family physician, I am strongly supportive of H.R. 2125.

Nemours also supports the Improving Social Determinants of Health Act and the Social Determinants Accelerator Act, which would invest in Federal, State, local, and organizational capacity to address the social determinants of health. One social factor of particular importance to the health of children is the health of their mother, which is why Nemours supports the Data to Save Moms Act and the Social Determinants for Moms Act. We believe these bills are a very important step in addressing maternal health outcomes.

Another important opportunity relates to data sharing across sectors. In my prior role as the secretary of health and social services in Delaware, I saw firsthand that, with the right data and technology systems, it was possible to better identify high-risk populations, reveal where disparities exist, and implement targeted interventions at the individual and population level.

We are seeing pockets of innovation across the country and making exciting progress in Delaware—the Delaware integrated data system in order to integrate data across multiple agencies that provide services to families. We in Delaware are launching a screening tool to help identify special needs, partnering with Delaware 211, and creating a central resource.

To catalyze and spread this needed innovation, Nemours supports the LINC to Address Social Needs Act, which would also support public-private partnerships to develop or enhance integrated, cross-sector solutions. We believe that—for delivery and payment models, and you have heard a bit about how that can happen. So pairing with work to advance and incentivize valuable payment and delivery models can incentivize health.

The COVID-19 pandemic laid bare the inequities that exist across so many domains. Out of this historic challenge is an opportunity to rethink the way we deliver healthcare, starting with pediatrics. We encourage the subcommittee to build on this tremendous legislative work stemming from today's hearing to facilitate and incentivize—and family health models—the data. We look forward to continuing to work with you to advance equity and help create the healthiest generations of children.

[The prepared statement of Dr. Walker follows:]

Empowered by Data: Legislation to Advance Equity and Public Health
United States House of Representatives Committee on Energy and Commerce
Subcommittee on Health

June 24, 2021

Written Testimony of Kara Odom Walker, MD, MPH, MSHS
Executive Vice President and Chief Population Health Officer, Nemours Children's Health

Good morning Chairman Pallone, Chairwoman Eshoo, Ranking Members McMorris Rodgers and Guthrie, and Members of the Committee. My name is Dr. Kara Odom Walker, and I am the Executive Vice President and Chief Population Health Officer at Nemours Children's Health. I am honored to testify about legislation to advance equity and public health.

Nemours is one of the nation's largest multistate pediatric health systems, including two free-standing children's hospitals and a network of nearly 80 primary and specialty care practices across five states. Nemours seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine. Nemours also powers the world's most-visited website for information on the health of children and teens, KidsHealth.org.

The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves.

Decades of research demonstrate that substantially reducing disparities requires a multi-generational approach. Starting in the early years of a child's life, and even earlier with the health of the mother, provides substantive opportunities to build a foundation of strong health, education, and economic outcomes for future generations.ⁱ Evidence shows that factors like trauma and stress of a mother even before conception, during pregnancy, and throughout the early postnatal care period can impact the life course of her child.ⁱⁱ Other research shows how the preconception diet of a mother, her lifestyle and health behaviors, and the overall health of both parents can all have long-lasting impacts on a child's health and well-being.ⁱⁱⁱ

After birth, early childhood and adolescence are critical times of development when one's lived experiences can have long-lasting effects on adult health and wellbeing. Evidence on adverse childhood experiences – such as domestic violence, mental illness or having an incarcerated family member – are strong indicators of poor adult health, health risk behaviors, and even chronic diseases.^{iv,v} Studies show that Black and low-income individuals are far more likely to report adverse childhood experiences compared to White or higher-income individuals – partially explaining the significant adult health disparities that exist between these groups.^{vi,vii}

Even without accounting for specific adverse events, poverty alone is associated with negative outcomes. Children raised in low-income households are more likely to have poorer neurocognitive outcomes, less educational attainment, and lower economic productivity in adulthood – all in turn contributing to the repeated potential for intergenerational poverty.^{viii} Children who live in the most economically disadvantaged counties in America die at rates up to five times those of their peers in the same state. The same children are three times more likely to lack regular access to healthy food and are 14 times more likely to drop out of high school. In addition, teen pregnancy rates are up to 26 times higher in these counties.^{ix}

If effectively implemented and designed in consultation with those they intend to serve, numerous policy approaches starting during pre-conception, continuing through childbirth, into the early years and through adolescence can substantially reduce disparities among underserved populations. Policy solutions and strategies must target cyclical and intergenerational disparities that persist – especially given that many communities have disproportionately shouldered and experienced the negative impacts of the COVID-19 pandemic.^x

Nemours is very appreciative that the sub-committee is considering various bills to reduce disparities, promote equity and address maternal health.

Legislation focused on Medicaid and CHIP

In particular, we appreciate the consideration of legislation that leverages opportunities in Medicaid and the Children’s Health Insurance Program (CHIP) to advance equity and improve health. According to data that the Centers for Medicare and Medicaid Services (CMS) released this week, of the 50 states that reported total Medicaid child and Children’s Health Insurance Program (CHIP) enrollment data for January 2021, over 38.3 million children were enrolled in Medicaid and CHIP combined, representing approximately 50% of the total Medicaid and CHIP enrollment. These numbers highlight the essential role that Medicaid and CHIP play in providing coverage for millions of vulnerable children and adults.^{xi}

The pandemic has laid bare the many health-related social needs of children and families. Medicaid is an important lever for coordinating care and making connections to address those needs. Nemours supports the CARING for Social Determinants of Health Act (H.R. 3894) and commends Congresswoman Lisa Blunt Rochester and Congressman Gus Bilirakis for their partnership and leadership in introducing this bill. H.R. 3894 would require the Secretary of Health and Human Services (HHS) to update guidance to state health officials regarding strategies to address social determinants of health in Medicaid and CHIP and provide a compendium of examples within two years of enactment and every three years thereafter. Notably, it would require that the updated guidance include strategies specifically targeting the pediatric population and pregnant and postpartum individuals. In doing so, this bill would ensure that as new bright spots and approaches emerge, they are disseminated to states to spread what works.

Nemours also appreciates the subcommittee’s consideration of H.R. 2125, the Quit Because of COVID-19 Act, introduced by Congresswoman Blunt Rochester and Congressman Brian Fitzpatrick. This bill would expand coverage of comprehensive tobacco cessation services for individuals covered by Medicaid and CHIP. One of the many benefits of increased access to cessation services and decreased tobacco use is the potential for reduced secondhand smoke exposure in infants and children. Infants exposed to cigarette smoke, whether in utero or as secondhand smoke after birth, are at increased risk of low birth weight, sudden infant death syndrome, ADHD, asthma, and other conditions. Exposure to secondhand smoke in childhood is associated with adverse effects on lung function, respiratory illnesses such as pneumonia and bronchitis, as well as increased hospitalizations in children with asthma.^{xii, xiii}

Tobacco is not an equal opportunity killer. For example, despite similar or lower smoking rates compared to other racial and ethnic groups, African Americans have the highest rates of tobacco-related cancer and are more likely to die from the disease.^{xiv} Smoking remains the number one cause of preventable death in the U.S., and many communities of color have been strategically targeted by tobacco industry marketing.^{xv} As a physician, I am strongly supportive of H.R. 2125 because it would increase access to and coverage for quality and evidence-based tobacco cessation services in order to help eliminate the disproportionate impacts tobacco and its deadly effects on America's communities.

Social Determinants of Health Infrastructure Investments

Policies targeting programs beyond Medicaid also have meaningful and lasting impacts. Nemours supports the Improving Social Determinants of Health Act (H.R. 379), introduced by Congresswoman Nanette Diaz Barragán, and the Social Determinants Accelerator Act (H.R. 2503), introduced by Congresswoman Cheri Bustos and Congressman Tom Cole. Both bills would invest in federal, state, local and/or organizational capacity to address the social determinants of health and contribute learnings to advance the field.

As these proposals endeavor to establish or improve SDOH infrastructure, one particular social factor of interest for children is the health of their mother. That's why Nemours also supports policies that specifically target maternal health, which is one of the earliest indicators of child health.

Maternal Health

Nemours supports the Data to Save Moms Act, H.R. 925, introduced by Congresswoman Sharice Davids, and the Social Determinants for Moms Act, H.R. 943, introduced by Congresswoman Lucy McBath. Both bills, which are included in Congresswoman Underwood's Black Maternal Health Omnibus Act (H.R. 959), focus on improving maternal health by addressing the causes of poor maternal health outcomes, including maternal mortality. We know that the health of mothers significantly impacts the lifelong health trajectory of their children. Further, according to the Centers for Disease Control and Prevention (CDC), Black women are three times more likely to die from a pregnancy related cause than white women.^{xvi} H.R. 925 is critical to better understanding the various indicators and contributors to death among postpartum individuals. H.R. 943 directly addresses some of those factors by extending programs and services to postpartum individuals and their children, including child care, housing, health care access and nutrition programs. It also requires the HHS Secretary to convene a task force to develop a strategy to coordinate efforts between Federal agencies to address social determinants of maternal health with respect to pregnant and postpartum individuals.

We believe these bills are a very important step forward and appreciate the subcommittee's leadership in considering them.

Additional Opportunities: Enhanced Data-Sharing across Sectors and Value-based Payment

In addition to policies addressing needs through Medicaid and various other federal programs – such as those proposed in several bills this subcommittee is considering today – it is critical to support communities in improving data collection and exchange.

Unfortunately, our health and social services programs and systems – as well as their underlying infrastructure – function largely independently of one another, making coordination of services, data sharing, and integrated financing difficult to achieve. These challenges strain the social safety net and place unnecessary burdens on those we seek to serve. In my prior role as the Secretary of Health and Social Services in Delaware, I saw firsthand how much opportunity exists to improve critical data systems in support of public health promotion and protection. With the right information and the right technology systems, it is possible to better identify high-risk populations, reveal where disparities exist – whether by race, ethnicity, zip code or some other factor – and implement targeted interventions at both the individual and population level.

Over the past few years, CMS and HHS have taken significant steps to improve interoperability and exchange of health data. Yet, public health entities, social service organizations, and community-based organizations have not benefitted from the same level of infrastructure, coordination and investment, and often experience difficulty in sharing information with health care organizations.

The good news is that despite this, we are seeing pockets of innovation across the country through statewide or regional efforts such as North Carolina’s NC360 initiative. Many of these initiatives leverage closed loop referral systems, which enhance existing health care technology, such as electronic health records and health information exchanges, by providing clinicians with the ability to make electronic referrals to community organizations and receive notifications when those referrals have been completed. These systems can help clinicians, public health and social services providers, schools and child care providers support children and families.

We are continuing to make exciting progress in Delaware, as well. At the state level, Governor John Carney’s Family Services Cabinet Council (FSCC) has begun collaborating to develop the Delaware Integrated Data System (DIDS) in order to integrate data across multiple agencies that provide services to Delaware’s families. The DIDS helps to link administrative data and develop predictive analytics to better prioritize program evaluation and inform resource allocation.

At the clinical level, in Nemours primary care practices in Delaware and Pennsylvania, Nemours has launched a screening tool to identify the social needs of the children and families we serve. At the same time, we are partnering with Delaware’s 211 program with the potential to enhance capabilities so that that Delawareans will have a central resource for accessing health and human service organizations that can address identified needs. We are encouraged by the possibility that these partnerships could bring in the future to help us better serve children and families.

There is great potential to learn from early adopter, successful programs and support states and communities in developing their own solutions. To help catalyze and spread this needed

innovation, Nemours supports S. 509 the LINC to Address Social Needs Act. This bill, which has been introduced by Senators Dan Sullivan and Christopher Murphy, would provide states with up to \$150M for public-private partnerships to develop or enhance integrated, cross-sector solutions to better coordinate health and social services.

Nemours believes that data infrastructure and data-sharing is a core building block in a high-performing health system. However, data-sharing is necessary but not sufficient to achieve the transformation we need. We must also leverage what we learn from our data to evolve our public health system, as well as our delivery and payment models. With a grant from the Robert Wood Johnson Foundation and support from the Center for Health Care Strategies, Nemours, Delaware Medicaid and Amerihealth Caritas Delaware are involved in a partnership called *Advancing Health Equity: Leading Care, Payment, and Systems Transformation*. We are examining our data and existing measures for children to determine where disparities might exist. This is emerging work, and there is a role for Congress and CMS to help facilitate, incentivize and scale these types of partnerships. We urge Congress to develop and advance legislation that would promote and incentivize pediatric value-based payment and delivery models that are centered in equity and pay for health.

Conclusion

The COVID-19 pandemic laid bare the inequities that exist across so many domains. Out of this historic challenge is an opportunity to rethink the way we deliver and pay for care, starting with pediatrics. We encourage the Subcommittee to build on the tremendous legislative work stemming from today's hearing and help to facilitate and incentivize whole child and family health models that address social determinants and advance equity so that all children have the healthy start they deserve.

Thank you for the opportunity to testify today. We appreciate your efforts and look forward to continuing to work with you on additional opportunities to advance equity and help create the healthiest generations of children.

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Ms. ESHOO. Thank you very much for your testimony, Dr. Walker.

We will now move to Member questions, and the Chair recognizes herself for 5 minutes.

To Dr. DeSalvo, you were the health commissioner of the City of New Orleans. Describe for us, please, the public health data that was available to you in that position. How old was it? How was it collected? Was there the ability to share with other community-based organizations?

And also, describe the ideal for public health data for local health officers. Would it be real-time? Would it be accessible? Would it be shareable?

And any comments, recommendations, critiques you have of the bills that are being considered today?

Dr. DESALVO. Thank you, Congresswoman. Yes, I had the great honor of serving the people of New Orleans. It was at a time when data systems were even more nascent than they are now. And we had to do a lot of work to just understand what was on the minds of the people in our community, through coffees in community centers or in church halls. And it was an inefficient and incomplete way to really understand the health of our community.

I had to do that kind of work, in addition to the quantitative data I had, because, to your question, a lot of the data and information local health officers even have now is stale, old, a couple of years, often. So I am—I was looking in the rearview mirror and didn't have a good sense of what was happening in the now for my community, much less how to forecast what might be happening in the future.

There were—when you are a local health officer, you also have this sense, Congresswoman, that you are swimming in data all around you, but you don't have access because it is in silos, whether that is in electronic health records or in—even public health data systems. And it isn't designed or built to be interoperable and give you the answers that you need about inequities, for example.

So the ideal systems are really ones that are, by design, thinking about data harmonization, and the committee is looking at some bills like H.R. 2503 that talk about the important need to, by design, build open standards that are interoperable so all these systems talk to each other.

We have good standards that we can draw from that we began to build for the healthcare system. So a different use, it is in public health, but basically it is a way to measure things like blood pressure consistently and record that.

The same thing for an important public health challenge like maternal mortality, which you mentioned.

So we have to be able to have a standard way that communities can collect and then act on the data.

I would say the other important component of the data systems is to feel more comfortable using novel signals. This is the imperative in the 21st century. And there is work that, for example, using information on public sentiment, or in our case we have made available a search symptoms trends data that can give information about what is on the community's minds. And the way I used to go into the church hall and talk to folks, it is another way to get

more quantitative information that is anonymized and private to augment other data systems. And it is more timely, actionable, granular than the kind of data that most public health has right now.

Ms. ESHOO. That is fascinating. Let me ask Ms. Blauer and Dr. DeSalvo. In both of your written testimonies you say that hospital data is some of the most reliable data.

And Dr. DeSalvo, I was especially struck by your point that hospital records are what enabled health officials to sound the alarm about the Flint water crisis. So my question is, why is hospital data so reliable, and how can we make this data more widely available to local health departments?

I am assuming that there isn't interoperability between the public agency and the hospitals.

Dr. DESALVO. Congresswoman, in the HITECH Act we invested resources to digitize healthcare. So now we have relatively reliable data in the healthcare systems that we have already shown can be used for public health crises like identifying Flint. There is a system in New York City that can identify chronic disease. And in Massachusetts there are also systems that can look for communicable disease outbreaks.

So—but there are some examples where we know that that data is helpful in identifying public health challenges. The reality is, also, that in HITECH public health wasn't resourced to be able to receive that data and anonymize it and make use of it in the way that Dr. Blauer has, for example, in some of the work that she has done to create dashboards that really—they can be useful to the community and to the country. So it is an untapped resource that—but there are some great examples.

I might even call out Oklahoma, another State that has been using EHR data to look for public health challenges. But it needs to be scaled. We need to do more to make sure that those systems are interoperable. And this is an historic opportunity in the bills that you have before you to begin to move in that direction, to really think about designing with a standardized approach and being able to make that information useful, not just for individuals but also for the public's health.

Ms. ESHOO. Yes, most helpful, most helpful. Thank you.

The Chair now recognizes our wonderful ranking member, Mr. Guthrie, for your 5 minutes to question.

Mr. GUTHRIE. Thank you, Madam Chair. I appreciate that. I appreciate the recognition.

Actually, if you look at Mr. Curtis' bill, he is looking at changing the medical loss ratio to incentivize spending on social determinants of health, such as Medicare Advantage plans do and I think Medicaid managed care does, as well. And Dr. Burgess' bill looks at collecting data on social determinants of health so that we can use this information.

I think what Medicare Advantage does is important in order to lay out what private health insurance plans, if they had the flexibility, would do. And I have a couple of questions.

One, Dr. Batra and Dr. Syed, if you could address this—you know, and I know the reality of it, but one of the criticisms, which I think is inaccurate, is that, if you have Medicare Advantage

plans, they cherry-pick—you cherry-pick who is in your plan. And therefore, obviously, if you are a health insurance company, you would, if you could cherry-pick, pick healthy and not people with other conditions. But it is quite the opposite with the flexibility incentives that Medicare Advantage has, and I think, Dr. Syed, you talked about that in your testimony, and Dr. Batra.

So you talk about—just kind of reemphasize, given the flexibility you have in Medicare Advantage plans to spend money on social determinants of health, one, that you are bringing in people that are—that have chronic conditions, that are sick. And not only are you bringing them into your program, but you are giving them far better services than they get in the Medicare fee-for-service plans. Could you address that, one, that the criticism of cherry-picking, if you do, which I don't think that you do, and the other one is how your plans are structured that are so much better for people with chronic conditions, like Mr. Curtis' bill is trying to allow health insurance companies to do with their medical loss ratio flexibility.

So, Dr. Batra, if you would, go first.

Dr. BATRA. Sure. So we serve about 15,000 duals, you know, so that tells you, out of a 220,000 population, 15,000 are on a fully integrated dual eligible special needs plan.

We also serve folks who are low-income subsidy folks. We serve folks who are in social vulnerability index four and five. So we serve all throughout the population.

If you look at the social HRA that I spoke about, about 10 to 15 percent of our people have indicated, when we do their initial HRAs, that they have food insecure. We have 2 or 3 percent of people who say they are housing insecure, many people who say—who are transportation insecure. So they are people from all backgrounds.

In terms of how we address their needs, it is through our supplemental benefits. We offer in-home benefits that include meals. We have a third of our population that complains of living alone and falling. We have benefits where we send up occupational therapists in their homes, so they can help with safety and be able to mobilize better within their own home setting.

So those are two very high-level examples. Transportation is a big issue if you are an older adult, especially during the pandemic, when you wanted to get vaccinated, you wanted to have access to that ride that would take you to where you needed to get the vaccine. That is the other benefit that we bring across.

Ninety percent of our membership, more or less, use medication, and 90 percent of that membership takes a zero-dollar medication. So that is what we also bring, is that affordability to them, so they can really—you know, and those are the people who can use that benefit. So we do serve people from all walks of life.

Mr. GUTHRIE. Thank you.

And Dr. Syed?

[Pause.]

Dr. SYED. Thank you.

Mr. GUTHRIE. If you would like to address it—OK, thanks.

Dr. SYED. Yes. ChenMed goes where the need is. And my biggest challenge, ever since I completed residency training, has always been access. And I have learned with Medicare Advantage that

Medicare Advantage opens the door. I mean, I am able to give my patients and their families my cell phone number. They call me if they are feeling, like my wife likes to say, a little icky. And if I need help getting a patient to stick to a treatment plan, I am able to call the kids and grandkids for backup.

My team texts my patients daily about health, simple messages like reminding them to get a flu shot or staying hydrated on a hot summer day. We even call our patients weekly. We call them love calls. Even if our patients feel good, they make them feel better, just by saying hello. And I am able to see my patients at least on a monthly basis. This is how we are able to prevent little problems from becoming big ones.

I—food—when I think about the social determinants, I think about food insecurity and—

Mr. GUTHRIE. Unfortunately, I only have about 18 seconds left.

Dr. SYED. Oh, sure, sorry.

Mr. GUTHRIE. So I apologize.

Dr. SYED. Sure, sorry.

Mr. GUTHRIE. I just wanted to kind of summarize and tie this to the legislative hearing that—H.R. 976, giving private insurance plans flexibility within their medical loss ratio, will allow other plans like Medicare Advantage to social determinants of health spending that are important to the healthcare, even though it may not be directly to—through their healthcare spending, but the things that matter on people being healthy. And that is why I think this is an important discussion.

So thank you very much. And I appreciate it, and I yield back my time.

Ms. ESHOO. The gentleman yields back. The Chair now recognizes the chairman of the full committee, Mr. Pallone, for your 5 minutes of questions.

Mr. PALLONE. Thank you, Chairman Eshoo, and thanks to the witnesses for being with us.

As we know, robust public health data plays a critical role in improving public health. And I wanted to start with Dr. DeSalvo.

You have worked firsthand both in the Federal Government and in industry on improving the collection and sharing of health data, and know well how these investments can help improve health outcomes. For example, you played a leading role in implementation of the HITECH Act. In your testimony you noted that CDC's data modernization initiative would benefit from the lessons of HITECH. So let me ask you, can you discuss, Doctor, further what lessons learned from HITECH should be incorporated into the policies that we are considering to improve public health data collection, if you will?

Dr. DESALVO. Thank you, Congressman. It is an important opportunity for the country to, of course, recognize that we have created a digital infrastructure for healthcare. On the other hand, we now are about to embark on something like that for the public health infrastructure. And I do very much appreciate your comments that this could be boring for some people, but it is vitally important to the health of our communities.

The specific areas where I think the country learned some lessons from the implementation of HITECH include, first, around

data and standards. That means, as we design the system going forward, what we should reflect on is that, rather than allowing each information technology system to develop its own proprietary standards, its own special way of doing things, we should create an open opportunity where there's shared standards. There's already—we don't have to invent many of those. There's organizations called standards bodies that are already working with the CDC and public health officials around the country to identify and clarify which standards we can use as the foundation, so the building blocks all talk to each other, and we start with interoperability as the base case.

The second is to make certain that we are thinking about the uses. What is the end that we have in mind? And, as the committee is articulating in a number of the bills, equity has to be a part of how we design this system. Yes, we need the system to be able to identify infectious diseases, and track on communicable disease for communities, but we also need to do that in a way that allows us to know where the resources need to be applied most. So building into that design, understanding of what are data systems that have to tell the story around equity, or around important public health challenges like maternal mortality.

The last thing I would say is timing. We pushed out the funding for HITECH, and the system stood up. There was some training for workforce, but it delayed a little bit behind when the systems were actually up and running. And I think what we all know is that it takes humans, it takes people to not only work those systems but to interpret the data and the public health—for the public's health, and work with community organizations to put it to good use to make change on the ground.

So we have to make certain that our workforce efforts are not only focused on COVID, but thinking more broadly about the infrastructure of public health and how to make that a durable, long-standing opportunity to make good use of the data to improve health and equity in communities.

Mr. PALLONE. Let me ask about resources, because, you know, Congress has provided funding for public health data and modernization in the CARES Act and Rescue Plan appropriations. But these were one-time investments. And you said that health departments need stable resources.

So the LIFT America Act, which was introduced by Energy and Commerce Democrats, has this core public health infrastructure program to help fund public health needs such as facilities or equipment upgrades, workforce capacity, health info systems. Can you just comment on this program?

In your view, what further steps should the Federal Government be taking to help improve public health data collection?

Dr. DESALVO. Well, I—Congressman, I first want to just say thank you to Congress for recognizing how important the issue is. The public health community, of which I am a member, really is appreciative of the opportunity to meet the needs of the public.

However, I think you are raising the important point, that it—data doesn't happen in isolation, it requires a system, which means we not only need to have strong data systems upgrades initially, but they have to be durable and sustainable, so that the health de-

partments can refresh the computers they have, or the—refresh the IT security systems that they have over time. So it is an ongoing commitment that they would need to make, to make sure they can meet the population's needs.

They also need workforce, they need partnerships, they need basic infrastructure to keep the lights on every day. I mean, it is really—would be hard to explain for many people in America how underresourced and challenged many health departments in America are. I used to say when I was health commissioner, we do our work with two nickels and some friends, and we are really thankful for a lot of our friends.

This is an opportunity in this pandemic, a learning moment, that we have a critical infrastructure that has been struggling to meet the needs of the population's health, is ready to do more. And I think, through partnership, we certainly can think about investing in the whole system, not just the data systems. But I think we are on a good path, as a country.

Mr. PALLONE. All right. Thank you so much.

Thank you, Madam Chair.

Ms. ESHOO. The gentleman yields back. The Chair is now pleased to recognize the ranking member of the full committee, Mrs. McMorris Rodgers.

You have 5 minutes for your questions.

Mrs. RODGERS. Thank you, Madam Chair.

Dr. Syed, we are talking a lot about the need for more data. I wanted to ask, based upon your experience working at a FQHC and at ChenMed, can you just further elaborate on the role of the doctor-patient relationship in addressing social determinants of health?

Dr. SYED. Thank you. It is so important for doctors to know about every emergency room visit. I was shocked when, during my time at the FQHC, that half of all medical care in the City of Tampa was delivered in the emergency room setting, and then even further shocked, when I joined ChenMed, that in the United States, at least pre-COVID, half of all medical care was delivered in the emergency room setting. So doctors must know about every emergency room visit. They must know about things like when a patient doesn't fill their prescription refill. They must know about every referral when the patients are being referred to specialists.

It is so important for doctors to also understand the costs of healthcare. You know, doctors should be more concerned about the medical complexity of their patient, rather than the medical complexity of the charting, which, unfortunately, is what we see in the fee-for-service healthcare system.

Mrs. RODGERS. Thank you.

Dr. Batra, on Capitol Hill right now there's a number of Members, Democrats, that have been promoting the Medicare for All proposal. And the effect of Medicare for All would be to ban private health insurance plans, including Medicare Advantage plans.

When you look at who is leading the way right now in addressing social determinants of health, it is really private—it is the private sector—by the work that SCAN is doing. I wanted to ask, are there specific programs that you would like to highlight, as far as the

success that could be implemented by employer or individual health insurance plans?

Dr. BATRA. Absolutely. Thank you for giving me the opportunity. I think one of the programs that I highlighted, I—we call it the peer-to-peer program, and I think that has played a key role for us.

I absolutely agree with Dr. Syed. Physicians are busy, physicians really want to build that trust, but we also know that trust can be built with peers. So we have been utilizing our own members to engage with members in a way they can relate to in the way they can empathize, in the way that they can understand around barriers that are big for this older adult population. Social isolation: 30 percent of our members tell us they feel lonely all the times or more than half the time.

Similarly around incontinence and falls, so our peer-to-peer program, which extends the reach of the physician team, has been able to do that. So I think that is a very key program.

The other program I would quickly like to highlight is our community health worker program. If we truly want to address health outcomes in an equitable manner, we need to recruit people from the community that have the trust of the community, that can build on the trust of the community, that can not only help them navigate this very complex healthcare system for our members but also be able to connect them to community-based resources if they are not available, let's say, with an MA plan, in terms of benefits and programs.

We have a very successful program we just published in a very well-reputed Journal of Geriatric Society. And that is exactly what that program does, is it takes the physician's care plan and makes the care plan really happen where the patient wants it, in their home setting, in the community setting, versus in the ER, in the hospital.

Mrs. RODGERS. Thank you. Thank you.

Dr. DeSalvo, the CDC has received over \$1 billion from COVID relief packages to update, modernize public health infrastructure at the State, local, and Federal level. I wanted to ask, what are the metrics that you would recommend that we use to determine whether or not those dollars are being spent wisely and driving results?

Dr. DESALVO. Congresswoman, thank you for the question. And I think we can learn a lot from what has already worked on the ground. I will begin there.

In States like Washington State, particularly a community like Spokane, that has a lot of historic work that it has done in partnership with community to address the public's health—it was one of our Public Health 3.0 communities that I visited when I was in the administration, and learned from—and what you learn from that is begin with the end in mind.

And as a country, if we want to address inequities in top public health issues, there are bills before us today, for example, about maternal mortality and the disparities in it for Black women, in particular. We could begin with what—we call that—and then work backwards, and say—then we need data that is going to inform actions at the community level to drive change.

I will particularly call out, though, I think the importance of what was asked for in the data modernization initiative by Congress, and that was for CDC to develop a strategic plan, and because that will be essential to have clarity about what needs to happen by when and by whom. Those are the use cases. And then, rather than just collecting data for data's sake, it must be done with the intention of improving the public's health, going forward. So a strategic plan, led by CDC, which is called for.

And I think, in addition, I would just call out Congressman Burgess' bill to think about what is already happening at HHS, and this opportunity to do an assessment inside of the government of what are the levers that could be used. Once we understand from the data the challenges that need to be solved, how can we act on that to improve health equitably and address social determinants, because there are many—probably already underway, and it would be good to not be duplicative, but to make sure that we are being as efficient as possible, because the public is counting on it.

Ms. ESHOO. The gentlewoman's time—

Mrs. RODGERS. Thank you all.

I yield back.

Ms. ESHOO [continuing]. Has expired. It is a pleasure to recognize the gentlewoman from California, Ms. Matsui, for your 5 minutes of questions.

Ms. MATSUI. Thank you very much, Madam Chair, and I—this is a terribly important hearing we have today, with much legislation.

You know, last week we examined the importance of increasing vaccinations to improve public health. And I would ask the witnessed how we can help providers and public health systems modernize Immunization Information Systems to help support this goal.

And may I say this? Public health is so important. Public health involves the whole community. It involves people who don't have access easily to health systems. And I really feel—I have got a huge health system in my district, four major hospital systems. I really—I also have a great string of community health centers too. And I really have a wonderful public health center too. But I must say this, that we have not funded public health in the way we should be. And I think every time we get some sort of pandemic or some sort of crisis, we go back again and say, well, this is what we should have been doing. We can't do that any longer.

So I really feel hearings like this are so important because, you know, we look at the social determinants data, and that exacerbates health disparities. And the bills today we are examining can provide a range of solutions to capture these central data that is important to ensure that people don't fall through the cracks as they did this time, as we promote health and mitigate disparities beyond healthcare, including access to healthy food, education, housing, and transportation.

So I am really interested in exploring how we can strengthen public health reporting by leveraging both clinical and public health data. And a lot of this data is not just in the health arena, either, it is in schools and education systems. It is in—just as somebody said before, just listening to people, encouraging con-

versation. Those kinds of data are really important to actually understand fully what is happening.

Ms. Blauer, you highlighted the need for robust data collection and reporting systems at the local and State levels. And this on-the-ground expertise is really important. So, as we build out our health data utility infrastructure, how can we coordinate more on the State-level health information exchanges and other clinical data sources?

I know there is a lot of conversation that goes on with our community health centers and the public health area, but how can we facilitate this even more, so that it goes up—so that we can actually capture the data, understand what is happening throughout not only the State itself but throughout the regions?

Ms. Blauer?

Ms. BLAUER. Thank you, Congresswoman, for the question.

There are—one of the things I have learned in my experience in the public service is that there are some of the most important thinkers and subject matter experts across the board in government. We have some of the smartest thinkers, but we need to invest in the skills of subject matter experts to actually use data to solve hard problems.

So there is one part where—we need to start investing in the capacity of people who are actually charged with leading programs on how they can use data.

The health information exchanges are also incredibly rich resources that exist that have great data and great data skills, but there is a disconnect between the exchanges and those people on the ground who are responsible for delivering programs. And so we need to start thinking about how can we build the capacity so that we are scoping our problems, that we are thinking about our problems in a way that elicit the right kinds of data responses, and that we have the skills to actually take that data and apply it to solutioning.

Ms. MATSUI. OK, well, thank you.

Dr. DeSalvo, we are talking about structural racism here. It is a public health crisis. And I thank you for drawing attention to this in your testimony. This was a huge issue after Hurricane Katrina. And 15 years later, what has the COVID pandemic revealed about the structural racism in the digital infrastructure?

Dr. DESALVO. Thank you for raising the issue. It has been such an important conversation in the pandemic. But as you say, it is not a new conversation in many circles. We saw it very clearly after Hurricane Katrina. I saw it personally, as I was on the streets delivering care to people, that where you live matters so much.

It was described by another witness: a 25-year gap in life expectancy in New Orleans, a whole generation, based upon where people live. And where people live is not just about a choice, it is also about structural systems that cause redlining and other factors that make a difference in the access you have to food and education and economic opportunity.

It has really motivated many of us in public health to focus on this as a public health issue. In fact, in a recent National Academy of Medicine report I had the chance to coauthor with Bob Hughes

from Missouri, we talked specifically about how, coming out of the pandemic, equity and racism will have to be priorities for public health and that the data systems that are built will have to be capable of providing information not only about individuals and how their health is different—predicated on things like the color of their skin, or race and ethnicity—but also, what are the structural systems supporting them? What are the school food programs? What is the access to sidewalks, so kids can walk to school?

So it is a double-layer system, not just—that looks at people, but also at the context in which they live.

Ms. MATSUI. So thank you very much. I have gone way over my time. And thank you very much for your testimony.

And thank you, Madam Chair, and I yield back.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Michigan, Mr. Upton, for your 5 minutes of questions.

Mr. UPTON. Well, thank you, Madam Chair. Thanks for this hearing today.

The ability to access and use information is certainly critical to many aspects of healthcare and health system operations. And the further embrace of real-world data and evidence, including SDOH data, can all help improve the facets on healthcare.

The 21st Century Cures Act included provisions to improve data sharing through reforms to the statute created by the HITECH Act that established the Office of the National Coordinator, ONC. However, as we know, this issue is bigger than ONC. How we use the data today is negatively impacted by a number of things, including how we regulate data use, or how capable the agencies of HHS are using the data well.

Representative DeGette and I released a discussion draft earlier this week that we are calling Cures 2.0 to help solve some of the issues that we are discussing. I would like to focus on two of those provisions.

Ms. Blauer, section 304 of Cures 2.0, entitled “Increasing Use of RWE,” builds on FDA’s efforts by requiring HHS to outline approaches to maximize and expand the use of RWE, and establish a task force to develop recommendations on ways to encourage patients to engage in RW data generation. So as we consider ways to improve data access and use—in use for many in health, how important is the patient participation in data access for the FDA or other healthcare operations?

Ms. BLAUER. Thank you, sir, for your question.

So I want to start by saying that I think a lot about resident engagement and patient engagement in data across the board. I think we need to be incredibly comprehensive as we think about how we reflect the realities of life in a way that we collect data, and patient information is at the center of that consideration.

So we have to, obviously, make sure that we include all of the protections and the privacy and advocacy that is required to keep people’s personal information safe, and make sure that they are informed significantly in order for the safe collection of that qualitative contribution to data collection, but also to really understand why it is important to have individual information as part of a consideration for data collection.

Mr. UPTON. Thank you.

Dr. Walker and DeSalvo, my staff over the years has communicated with CMS and other agencies about the current capabilities of their computer systems. Generally speaking, the feedback has not been terrific.

One provision of Cures 2.0 would begin the process of Congress working with HHS to update CMS and other computer systems with the goal of helping these agencies use the data better. So as we consider the bills before us today, I am curious to your thoughts on whether improving CMS data capabilities through modern computing approaches can help support our goals.

[Pause.]

Dr. WALKER. Thank you. I will go first, and I really appreciate the opportunity.

From a State perspective, we certainly would appreciate having additional support for CMS to update systems, to allow for us to work together as States try to engage and leverage data that is available. I think, as we learn more about the impacts of social determinants of health, there are models that can test how we support payment strategies and delivery system innovation.

For example, the CMMI's Integrated Care for Kids model and the maternal opioid use model, as well as other programs like Medicaid waivers, really allow you to look at how you are investing in the earliest years of life. But the challenge is understanding what is working, and you need data to do that programmatic evaluation and assessment.

We know, at Nemours, as we try to deploy value-based services and new types of care delivery, we absolutely need opportunities to work with CMS to develop demonstration models to invest in the data and really figure out how to implement value-based care.

Dr. DESALVO. I will just maybe add a related issue, if I could, Congressman, which is to—first of all, I am not an expert in the CMS data systems, though my appreciation is that they are in need of some upgrade. And I think, as Dr. Odom Walker is describing, that opportunity there has to do with making sure that we can meet the needs of the population's health, using data that can support value-based care models or global health models.

But I particularly wanted to call out that in Cures 1 there was a push towards open APIs, FHIR-based systems, which I know you and your team are familiar with, those same models can be applied to public health. And as we think about modernizing the public health data infrastructure, and because of 21st Century Cures, there has been a movement in the field with public health and the digital world to create that kind of an interoperable system, so we don't repeat any of the mistakes the country made with HITECH. So thank you for that direction envisioning.

Ms. ESHOO. The gentleman's time has expired, and I thank him.

It is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for your 5 minutes.

And I want to remind Members that questions are being—those that are—I am sorry. We are calling on Members in the order of subcommittee seniority, OK? Just as a reminder.

Ms. Castor, you are on.

Ms. CASTOR. Right. Thank you very much, Madam Chair. Thank you for calling this very important hearing, and thank you for including my bill with Congresswoman Underwood, the Ensuring Transparent, Honest Information on COVID Act, the ETHIC Act.

Colleagues, this committee, Democrats and Republicans, have really shined the light on the lack of transparency and the consistency around COVID-19 data during the pandemic. And I think there are three main issues: one, many local communities and States did not have the modern data reporting systems in place; two, there was a troubling pattern in a number of places of withholding COVID-19 data, censoring of data, whether it is nursing home infections and deaths or overall mortality rates, or testing, very serious issues there; and then three, of course, we don't have the Democrat—demographic data we need on health disparities, and we are—we have to do better on that.

Communities, businesses, public health experts need this consistent and transparent health information to help keep families safe, and to implement effective measures, and do it efficiently.

So through the bipartisan—as Chairman Pallone said, through the bipartisan emergency relief packages, this committee really helped direct huge new investments in—to update data reporting at the CDC. But we are going to need to provide additional direction. And in addition to the bills that get to it through standards, which is very important, the ETHIC Act also will do this through transparency and data reporting.

One, it will require States, local communities, Tribal and Territorial governments to report COVID-19 data, including demographic information to the CDC; and two, make sure that it is all reported up to the public.

And then, too, we are going to—we need to tap the expertise of the National Academy of Sciences Engineering and Medicine to review the current system and provide us with additional recommendations on public health data, infrastructure, and reporting.

So for Ms. Blauer, thank you so much for your longtime and very important work to improve health outcomes using data, but especially for your work and that of Johns Hopkins, the Coronavirus Resource Center, over the last year. In your testimony you say that consistency across States is going to be vitally important. You highlight the ETHIC Act—thank you very much—but can you also talk about how—what do you see that we need to do to ensure dependable, transparent data for the public, for communities, for businesses going forward?

What else do we need to be doing?

Ms. BLAUER. Thank you, Congresswoman, for the question. I can say with great authority that there is a hunger at the State and local levels for standards, for this common language that actually can help guide the way that we collect and think about data across our States and our cities.

We had, over the course of our managing the Coronavirus Resource Center, daily calls with mayors, with Governors, with people from local communities, from health departments that were seeking advice on how they should collect this data, how they should express this data to the public, how they should be thinking about

letting this data support their decision making, and they were searching for support and validation of their approaches.

So, again, while the systems that collected this data were often shoestring operations in some cases, started with manual collections that did mature over time, I think the reality is that these organizations across the board in State and local communities were really seeking that kind of high-level validation that what they were collecting and how they were using this data was the right path forward.

And they also wanted to be able to look at their neighbors and say, “I see that you are having better experience in managing this part of the pandemic. I want to learn from you.” And with—in the absence of those standards and that common language, it became very difficult to do apples-to-apples comparison across the geographies.

And so the role of Federal Government here could really be let’s create that common language, let’s provide those standards, and then let’s provide the support for the State and local communities who are going to be navigating these health challenges in a way that they can learn from each other, they can learn from their wins, they can learn from their failures, but then they can also think really critically about how they are applying that data to the policy levers that have been so critical to the way we have navigated the pandemic. Thank you again.

Ms. CASTOR. Thank you very much.

And I yield back.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Virginia, Mr. Griffith.

Mr. GRIFFITH. Thank you very much, Madam Chair. I am very happy to follow Congresswoman Castor talking about ensuring transparent, honest information on COVID-19.

Ms. DeSalvo, it is being reported that there are financial ties between Google and EcoHealth Alliance, a company that was collaborating with the Wuhan Institute of Virology to conduct bat coronavirus and other virus research. As donors to EcoHealth Alliance, do you support its lack of cooperation with my request and the requests of other members of this committee as we seek information about the origins of COVID-19?

Dr. DESALVO. I appreciate the question, Congressman. I don’t have all the details of that report, but I believe the reporting has been inaccurate. The one-off grants that were received by that researcher were years ago and predate the pandemic. So my appreciation is they are not related.

Mr. GRIFFITH. Well, and they certainly predate the pandemic, as far as the base research. But the data indicates that there was a 2010 study on that bat flaviviruses that was listed as being supported by Google. There is also a 2014 study on—if I am pronouncing it correct—henipavirus, which infects fruit bats and micro bats. And that was in—on the spillover. And then a 2018 EcoHealth Alliance paper entitled, “Serologic and Behavioral Risk Survey of Workers with Wildlife Contact in China.” That was made possible with the contributions of Google.

So it is—it clearly predates the coronavirus outbreak, but this research has been going on for over a decade. And the real question

is, does Google support or condemn EcoHealth Alliance that they donate to?

Do they support or condemn the stonewalling of Members of Congress who are trying to get information about what happened with COVID-19, and what the origins really are, whether it was a wet market situation or was it a lab leak?

Dr. DESALVO. With respect to the—to this particular investigator, or set of investigators, as I said, I haven't seen the reports, and I am not intimately familiar with the work.

What I can submit to you is that we will work with you and your office and come back with answers that you may have—and see that we have the right people who have more intimate knowledge of the situation.

Mr. GRIFFITH. And I appreciate that. I would also appreciate any conversations, emails, et cetera, that Google may have had from EcoHealth Alliance that may have indicated to them information about COVID-19, since you all were involved in earlier studies related to bat viruses that Mr. Daszak of EcoHealth Alliance was one of the authors of, saying that this was clearly coming from wet markets and from bats, and you all were involved in that. Any conversations you all might have had in 2019, 2020, or 2021 regarding that, if you could get me that information, that would be greatly appreciated. And can you commit to working with us to get that information?

Dr. DESALVO. I certainly commit to working with you all, and I will have the right people follow up with your office.

Mr. GRIFFITH. I appreciate that greatly. You know, it is important that, as we talk about having an honest and transparent discussion about these items, that we move forward working together. And is Google prepared—because it has been criticized in the past for failing to demonstrate a commitment to fostering open debate on scientific issues such as this—is Google prepared to commit to such an open debate?

Dr. DESALVO. I tell you, Congressman, I very much appreciate you asking that, because, as a physician, the debate about the medical treatments and origins and even the diagnosis of COVID has been a rich and complex environment for the past year and a half, and not only for the medical community and the public health community, but the community at large has been involved in trying to understand, as we learn on the journey, what works, what doesn't work, how should we be protecting people in communities, how should we treat our patients in the hospital or at home.

So as that information has evolved, we have relied on trusted authorities like the CDC or the World Health Organization outside of the U.S. to provide authoritative content, so we can lean on the group of scientists that build consensus statements from those authoritative groups. And then we use that to inform policies that we apply to information, not only to raise up important quality information that we want people to have, people—to protect themselves and their families, but also—

Mr. GRIFFITH. Yes, ma'am.

Dr. DESALVO [continuing]. Harmful misinformation.

Mr. GRIFFITH. And I appreciate that. And I think we should go forward working together. And I hope that Google will have an

open policy on scientific discussion, because the EcoHealth president has recently been taken off of or left the WHO study, and it is now becoming clear that they are somehow involved. We don't know exactly how, because they are stonewalling us. And all we want here are answers to the American people.

I yield back.

Ms. ESHOO. The gentleman yields back. It is a pleasure to recognize the gentleman from Vermont, Mr. Welch, for his 5 minutes of questions.

Mr. WELCH. Thank you very much. I want to thank all the witnesses for being here. And I want to bring up Congresswoman Bustos' Social Determinants Accelerator Act, and I am a cosponsor, and it is really important in Vermont.

In—the Vermont housing needs assessment in 2020 showed that more than 19,000 Vermont households face housing quality issues. It includes homes with coal or limited heating sources, 40-year-old mobile homes, incomplete plumbing, and so on. And, unfortunately, too many Vermonters do live in these conditions.

Dr. Walker, you mentioned the Social Determinants Accelerator Act in your testimony. And the bill, as you know, would create a program at CMS to provide grants to State and local governments to develop plans to combat social determinants of health that are resulting in negative health outcomes. The—are you aware of any cities or States who have developed a strong model to improve housing and health outcomes at the same time?

Dr. WALKER. Thank you, Congressman. I think there are a variety of examples that are critically important, not only around housing, but also around nonmedical transportation, home-delivered meals, and educational services. And some States have incorporated waivers into their Medicaid program. I think a few examples exist, including North Carolina, where they are incorporating this into their value-based payment. Maryland is certainly implementing a program to support individuals with developmental disabilities. And there are others—Minnesota's waiver that looks at the provision of housing stabilization for individuals who are at risk for homelessness.

I think using these examples and innovations are helpful. They also allow us to invest in families with long-term impacts on the health and wellness and mental health and well-being of children and adolescents. And so having these examples is helpful, but encouraging it across our Nation could be a tremendous health impact.

Mr. WELCH. Thank you, Dr. Walker.

And Dr. DeSalvo, you also discussed the need to address social determinants of health, housing being one of them. How can investment in updated health data systems, including the use of qualitative data, which you mentioned, help improve public health and build up our communities suffering from systemic health inequalities?

Dr. DESALVO. Thank you, Congressman, for the question, and I will answer it. I do want to first give a shout-out to Vermont, who has done some great work, particularly for populations with substance use disorder, in understanding how to blend and grade resources to address social determinants of health, including hous-

ing—housing being, for people, probably the most important social determinant of health. We saw that firsthand after Katrina, and we see that every day in communities. So I also appreciate you raising a really important foundational structure for individuals.

Two particular points. One is that data is—has to be timely, actionable, and granular. It has to be not only quantitative, because you need anonymous population-level information that you can map to direct intervention, but you also need the voice of community. Some of the bills today include that concept, that there have to be community advisory voices, particularly those bills—the bill about maternal child health.

But that is true in every context. And that can be done manually, if you will, human to human, and that is important. It can be augmented by additional data sources. I mentioned information that Google has made available to public health on the open repository, including search symptoms trends. Again, this is anonymized data that is at the population level that could be useful to augment that important data that public health needs to take action.

Final point, these bills, many of them speak to this idea of community collaboration and partnership. I think you will find threads throughout many of the successful projects in communities that it is really about everyone coming together to create the conditions for health, not any one sector alone. So public health with business, faith-based and others.

I will just—for your information, and for your staff, particularly, the NASDOH, the National Alliance for the Social Determinants of Health, has a report on their website that talks about some great examples across the country and a playbook for how communities can do this, including what the data needs might be.

Mr. WELCH. Thank you very much.

Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back. The Chair is now pleased to recognize Dr. Bucshon from Indiana for your 5 minutes of questions.

Mr. BUCSHON. Thank you, Madam Chairwoman, and thank you for having this hearing. This is really important.

Social determinants of health are critical in today's healthcare system to improving health outcomes and better understanding why social situations that people in our society are in actually have a substantial effect on their ability to lead healthy lives and to get good outcomes.

But it is a very complicated subject. I have worked on—a lot on maternal mortality and maternal health. And, you know, we have had testimony from physicians from Parkland Hospital in Dallas, for example, which—that is a public hospital for the underserved, and many of their patients are on Medicaid, and their health outcomes were outstanding as it relates to maternal health. And then we heard testimony from other areas of the country that also service underprivileged and primarily Medicaid patients, where their data wasn't quite as good.

So we really need to know why this is, and why that—and I think part of that is because Parkland Hospital has data-driven protocols to how they take care of patients, at least in the maternal health. But this is also across our healthcare system.

It is all about innovation, I think, in healthcare. Innovation and better-collected data help promote a more value-based system that, in my view, helps lead to better outcomes, because we are able to determine why the outcomes are poor in one area that serves a similar population but outstanding in another area of our society.

One area I want to focus on was the provider's role in gathering and collecting of data. As we know, doctor burnout is at an all-time high. Most of the time, the main reason, in my view, for this is due to the burdensome paperwork and duplicative administrative tasks that a lot of physicians don't feel they signed up for. They want to take care of people. All of this has doctors spending more time doing paperwork and less time with their patients. While I think data is important and should be incentivized, I am cautious not to put more of a burden on doctors and other providers who already need more time with their patients.

In that vein, Dr. Syed, it is my understanding that there are existing ICD-10 codes for social determinants of health that most doctors aren't collecting at the moment. In order to properly advance social determinants of health policies, someone will have to be responsible for reporting the data collected. In your experience, who is responsible for collecting the data needed for better social determinants of health?

And whose responsibility would it be if some of these bills considered today would become law?

Dr. SYED. Thank you. In my past life at the—in the FQHC world, it was in the fee-for-service system. It wasn't in a value-based system like I am currently in with Medicare Advantage. So I was forced to focus on sick care. I have always felt like I was two steps behind. I remember I was always reacting to problems that were already out of control. See, in the Medicare Advantage environment, practicing preventive medicine keeps all of us—not only the doctors, the nurses, all of our care team members—many steps ahead. And that is when you are able to notice the small changes before they really become the big ones.

So it should be the primary care doctor being at the center of the care delivery system.

Mr. BUCSHON. Yes, well, I appreciate that, and I think, you know, that does add some administrative burden. But I do agree that there has to be someone—the primary care doctor, you know, is kind of the captain of the ship. And so I just want to make sure whatever we do doesn't unnecessarily burden providers.

And so I want to talk a little bit more about your experience with—in Medicare Advantage. Why do you think it is more of the—that more of the Federal Government and State governments are so hesitant to embrace the existing approach that gives plans and providers a risk-adjusted amount of money that lets them decide which social determinate interventions need to take place without adding more burden-inducing reporting and box checking?

Because what you just described sounds better to me than maybe the system that you had experience with before.

Dr. SYED. Well, sure. I mean, all of us got into medicine to help people. None of us thought that we would be getting into healthcare and spend hours every day focused about the documentation required for reimbursement.

So what I would like to see is, really, more education about Medicare Advantage, because our current system is based on sick care rather than primary care. You see, with the Medicare Advantage model, it puts the primary care doctors at the very center of the entire care delivery system. You see, then the doctor has the time to look into the causes of the causes, and then you get to know the patients better than any other random doctor.

I think what you mentioned about the choice, patients should be able to go to any doctor they want whenever they want. And it sounds great in theory, but when your health is on the line, you really want a referral from the doctor who knows you the best, the one that you trust the most. And with the Medicare Advantage world, yes, I just want to say that, that it gives me the time to establish the trust with my patients and make the same referrals I would for my mom or my dad.

Ms. ESHOO. I hate to interrupt—

Mr. BUCSHON. Thank you for that information, and I yield back.

Ms. ESHOO. Thank you. Thank you very much, Doctor. It is a pleasure to recognize the gentleman from Oregon, Mr. Schrader, for your 5 minutes of questions.

Mr. SCHRADER. Thank you very much, Madam Chair, I appreciate it.

I, too, am a supporter and cosponsor of Ms. Bustos' bill on the Social Determinants Accelerator Act, and I think it is very important to have that coordination. We have heard here today from our witnesses and others that, without that coordination, it is very difficult to get things done.

And in my home State of Oregon, one of the big projects that has worked extremely well is our coordinated care organizations to deliver Medicaid or Oregon Health Plan benefits for a lot of folks. And they are grown up from the ground up. It is not something that is put top-down from Washington, DC. And it actually has those social determinants worked on by the community organizations that know that community best, and I think that is what Dr. Bucshon was alluding to, and I would agree with him.

We shouldn't be managing counting different things that should be about providing quality healthcare. Dr. Syed, I think, hit the nail on the head in his comments and responses there. I think it is just so important to coordinate this sort of thing.

Dr. Blauer, with the interagency council suggested in the Bustos bill, how do you see that getting out best practices like we have in Oregon to folks around the country?

Ms. BLAUER. Thank you, Congressman, for the question. I think the most important thing is that, oftentimes, particularly when we talk about data or IT infrastructure, our gut is to put data and IT folks on these interagency committees. And what we need are subject matter experts who are knowledgeable about the impacts of program decision making and the realities of program delivery on the ground.

So I think, first and foremost, you need to make sure that they are staffed with people who have deep, programmatic expertise and who understand what the objectives of the work are and understand how they can leverage tools and technology to actually do the

delivery of the services and to support the work of the committee. So subject matter expertise, absolutely.

And then prioritization. We need leadership that actually can lead with prioritization. We will end up in a boil-the-ocean moment if we don't have clear goals that are articulated and measurable and that we can focus our work collectively on. There is a lot of work to be done, and without that kind of direction that will allow for us to have those sort of clear priorities outlined, we are going to be in a situation where we are going to get overwhelmed very quickly. And governance allows you to create prioritization with the inputs of that subject matter expertise. Thank you.

Mr. SCHRADER. Very good. Thank you. Thank you.

Dr. Syed, you talked about being fully capitated. Fully—that that makes a difference. What is your definition of fully capitated to make the Medicare Advantage system work, in your eyes?

Dr. SYED. It is a model of—especially with primary care, where the doctors are not concerned about generating revenue by billing. Being fully capitated, we take on the full responsibility of the total health of the patient. And so it gives us the flexibility to treat seniors with multiple chronic medical issues according to their actual individual situations.

Mr. SCHRADER. I agree with that, and I think that is—points to Dr. Bucshon's concern about it shouldn't be the M.D. that has to worry about counting all the widgets and worrying about reimbursement. If you have a coordinated care group like we have in Oregon, that organization deals with that and decides, along with the physicians, with the hospitals, with the mental health providers, with the pharmacies, about who is getting what amount of money based on those local needs.

I don't see why we don't even just transition to that. Fee-for-service is so outmoded. I have remote parts of my district, very rural parts, that are part of coordinated care districts that provide much better health service tailored to those individuals.

Dr. Walker, I appreciate you mentioning the value-based payments, you know, as we just discussed here. Were—what policy should we be pursuing to foster growth in that arena?

We are actually trying to do that—Mr. Guthrie, Mr. Mullin, and I—with regard to pharmaceuticals. But I think it, obviously, applies here, in terms of just care delivery. What should we be doing to foster growth in that area?

Dr. WALKER. Thank you, Congressman, for the question. I think it is essential, as some of the bills indicate, that we need to incorporate incentives, expertise, and make sure that States have the bandwidth to move forward with value-based payment. That often can start with Medicaid but go beyond, once you learn the lessons. Medicare Advantage is fully taking on this value-based payment role.

But it does take a bit of guidance. And, you know, the Caring for Social Determinants Act does include a recommendation to include the updated guidance to allow for innovations like the CCOs to flourish in other places. But it does take leadership, it takes alignment, and it takes the right expertise. That is where, you know, having data to look at the alignment of incentives can be incredibly helpful too.

Mr. SCHRADER. Very good, thank you. Thank you all for your work.

And I yield back, Madam Chair.

Ms. ESHOO. The gentleman yields back. It is a pleasure for the Chair to recognize the gentleman from Oklahoma, Mr. Mullin, for your 5 minutes of questions.

Mr. MULLIN. Madam Chair, thank you so much. Thank you for putting this hearing together.

Dr. DeSavio—I hope I am saying that right. If I am not, please correct me. I—based on your experience in public as a public official, can you kind of speak to the importance of aligning Federal programs to address the social determinants of health?

Dr. DESALVO. Thank you, Congressman. On behalf of my husband's family, I will say it is DeSalvo.

Mr. MULLIN. DeSalvo, thank you.

Dr. DESALVO. You know, Congressman, in Oklahoma you have an incredible example of how a group of primary care clinicians came together to create an information exchange—this is My Healthy Data—and built a global population health model like we were just describing, to really allow the docs to care about the patients, and then the data gets collected around them, and the patients—that data now tells the story of a community's health, as well.

So it is informing public health action. It is a wonderful example of how Federal action to spur the innovation and models of primary care, of health information exchange can then also not only improve the care of patients but begin to tell a story and—or improve the care of populations that—that group, for example, has done incredible work in COVID, creating dashboards that can help the community understand—I believe you had the opportunity to see some of those. So—

Mr. MULLIN. I have.

Dr. DESALVO. You know, I think it is a wonderful, also, example of how the foundation of electronic health record information that—primarily for the use of individuals, when anonymized, can be useful to help understand the health of a whole community. And it is the kind of innovation that we could spur or scale across the country and shorten the timeline to being able to do good work.

What is great about that particular effort, by the way, is that it is transparent. The docs have a lot of say in the data and how it is used, but also it helps to build a virtuous cycle of improving the quality of care and, as I said, improving the health of the population.

Mr. MULLIN. Are there any examples, like, in your experience that you can use to kind of highlight on how this has been working?

Dr. DESALVO. Definitely. I think, in addition to the example in My Healthy Data, there's a couple of States that have been leaders in this area of using existing data that was built on a foundation, often from a Federal program, and then gets expanded.

I will call out another primary care example, one called Macroscope, which was built in New York City by the public health department using data from their primary care clinics, a similar idea. We already have data. Let's not repeat the collection. Let's be

efficient. Let's anonymize it and use it as a way to understand what are the rates of diabetes and high blood pressure in our community. And it is a pretty timely, actionable, granular set of data that public health now can use to target interventions, to address inequities, to address the social determinants of health.

I could go on a long list, Congressman, but I think what I would love for the committee and for others to know is innovation in—between public-private partnerships, community led, on the ground is happening all over America. I visited so many in the course of my career. We have written about them in Public Health 3.0 and the National Academy of Medicine report I referred to earlier that we just recently put out on public health. So we have a sense of what works and we have a sense also of what works from the data.

Now what we need to do is make sure that we have got strategy and prioritization and direction, but also fill gaps in the data layers and make sure that that data layer is interoperable and can help us address inequities.

Mr. MULLIN. Well, that actually leads me right into my next question, which was going to be: What can Congress do to kind of help—easier for private sector and nonprofits to work together on various funding streams to coordinate in this way?

Dr. DESALVO. This is an interesting and complex area. One of the calls that comes from community often is, when they create collaborations they want to not only share governance and data, but they want to be able to pool or share resources. And there are actually—there is more latitude, probably, than many communities realize. Communities like Oregon, or Rhode Island, Vermont have found ways to blend and braid funding to support particularly low-income populations and address social determinants.

But I will tell you what, I have done that on the other end, when I was health commissioner addressing needs of youth and violence. It is very hard to blend and braid funds sometimes. So I think some of the considerations in the bills—for example, these inter-agency councils—could be to catalog or understand what are the flexibilities that communities could use to not only blend and braid the public-sector dollars, but how can the private sector contribute in a way that is again, transparent, shared governance, and shared accountability for the outcomes.

Mr. MULLIN. Doctor, thank you so much.

And Madam Chair, I will yield back the remainder of my time. I want to thank you again for putting this together, though. This is vitally important to a lot of our communities, especially the rural parts of the country.

Ms. ESHOO. It is, and you asked wonderful questions. Thank you.

The gentleman yields back. The Chair now has the pleasure of recognizing Mr. Cárdenas from California for your 5 minutes of questions.

Mr. CÁRDENAS. Thank you, Madam Chairwoman, and also thank you, Ranking Member Guthrie, for having this very, very important hearing. And I always appreciate all of our experts coming to educate us policymakers so that we make sure that we can do the best job we can to serve our country. And we are up here on a 30,000-foot level, and you are there on the ground. So thank you so much for all of your expertise and your wonderful insight.

Also, Chair and Ranking Member, thank you so much for putting H.R. 3969 on the agenda today, as well. I am chairing that bill with Representative Curtis, and I appreciate it being in the hearing today. This bill would include spending on activities related to social determinants of health, and the calculation of private health insurance plans and medical loss ratio.

In introducing this legislation, we recognize that social determinants of health like reliable transportation, availability of nutritious food, safe housing are all primary drivers of health outcomes. And to achieve health justice and equality for all, we must be more intentional about how we address their impact in all parts of our healthcare ecosystem.

Dr. Batra, in your testimony you discussed the Senior Care Action Network, SCAN, the approach to addressing social determinants of health. Could you please talk about the impact of this approach on members in your network?

Dr. BATRA. Absolutely. I think we started off by making sure we collect data the way the members want the total data to be reported, how they identify. So for us, having the data around race and language was very important.

Similarly, we have collected years' worth of data on our members around their social needs, their transportation, food insecurity, loneliness, in-home caregiving and support, hearing dysfunction. And we have really used that data to help identify members and even connect them to the right benefits and the right programs.

So, for example, 70 percent of our population suffers from hearing dysfunction, which, as you know, can interfere with so many different things, lead to isolation, lead to loneliness, also lead to poor health outcomes. We have hearing aids as one of our supplemental benefits. So we try and engage with members and connect them to that.

Similarly, a good example during the pandemic was around transportation. People wanted to get the vaccine, did not have caregivers around them, had a son or daughter-in-law living in a different State. We were able to arrange those rides for them.

The other unique thing that we did during the pandemic and vaccination was, as people were getting vaccinated in doctors' offices and convention centers and pharmacies, we had folks who were homebound and could not leave their homes. We were able to get the vaccine to their home, not only for the members, but also the caregivers, because they were the ones taking care of their loved one, who happened to be with us.

So those are some of the high-level benefits that we have used. We have done studies that show that, if you have transportation insecurity or food insecurity, you are going to have a worse outcome on your diabetes. And so we are consistently looking at ways and engaging our population with—whether it be a program or a benefit, and ensuring them they have it, so as to fulfill their needs.

Mr. CÁRDENAS. Yes, thank you. And can you give us at least one example about what we can do, going forward, as Congress?

What kind of effort can Congress afford you out there in the community?

Dr. BATRA. Absolutely. So as we—you know, first and foremost, I want to really thank the Congress for providing us the flexible—

benefit flexibility. We were able to design all these newer benefits to meet the social needs of the population that started in 2019. So the benefits that I alluded to: in-home caregiving, meals after discharge, care coordination, support, and occupational therapist. However, these are based on medical needs, so you have to have a qualifying diagnosis, like you have diabetes or you have heart disease or end-stage renal disease.

If you truly believe there should be equality for all, if you truly believe that social needs are the first and foremost drivers of health, then perhaps we should be allowed to kind of design some of the benefits based on the social needs of the population. So that is one area that comes to my mind.

And the second area is, during the pandemic, as we were scrambling we did about 100,000 social outreach calls to—checking on members. We actually have a benefit that helps people sign up so they can—somebody can be their help, so they can have the telehealth visit to their doctors. We notice there are ZIP Codes with a high social vulnerability index, where people did not have access to Wi-Fi and iPads and technology. And for those, the telephonic assistance was really, really important in order to extend the reach of the primary care physician. That is the other area we really want Congress' help, in keeping telephone as one of the ways of engaging with the member, engaging with the patients, and helping them.

Mr. CÁRDENAS. Thank you, Dr. Batra. And it is very rare for us Members of Congress to get a thank you. So thank you for slipping that thank you in there.

And I just wanted to say how focused many of us are on making sure that we modernize our public health data, infrastructure, and outreach, because those are some of the major lessons that we learned during this pandemic.

My time has expired, Madam Chair. Thank you so much for having this hearing. I yield back.

Ms. ESHOO. You are most welcome. It is a pleasure to recognize one of the doctors on our subcommittee. And we have, I think, five. I think five doctors.

Dr. Dunn from Florida, you are recognized for your 5 minutes of questions.

Mr. DUNN. Thank you very much, Madam Chair, and also thank you, Ranking Member Guthrie, for hosting this hearing today to examine the ways that data can affect public health.

You know, over the course of the COVID-19 pandemic, Congress spent hundreds of millions of dollars to support data collection and data infrastructure modernization. And whether those dollars were used for a centralized CDC data assimilation or grants to States and local governments for data collection, the money is already out the door. And we need to evaluate how these funds are being used, I think, before we consider another slate of new bills to advance more data collection as it relates to improving the care of the health of the American people.

High-quality healthcare starts with the doctor-patient relationship. Dr. Syed said that in his testimony. And then it should consider the individual needs of patients. You can't just crunch data

and pigeonhole people without taking a holistic approach to the patient.

We also can't rely on bureaucrats in Washington to make decisions about healthcare for our individual patients. People simply cannot be reduced to a set of data points, no matter how voluminous they are.

I also want to associate myself with the remarks of my colleague, Dr. Burgess, when thinking about requiring more and more data collection. The potential that that information will be shared across other entities requires that we have reliably strong safeguards in place to ensure patient data remains private and that HIPAA protections are, in fact, upheld. And with that I would like to ask Dr. Syed a question.

I appreciated reading your testimony, hearing your views on creating more value in the healthcare system. You touched on coordination of care and a strong doctor-patient relationship and matching the resources to the patient's needs in order to drive improved outcomes. It seems to be you are an advocate for the flexibilities that the Medicare Advantage system allows, in terms of value. And you cited many examples in your testimony, and let me say I share those views with you.

From your perspective, is increased data collection in the primary care setting the sine qua non to improved health outcomes?

And so a lot of these proposals are talking about involving significant additional reporting requirements and gathering a great deal of data. And I know personally that doctors are already suffering from a fair amount of burnout and stress over administrative burdens. Dr. Bucshon made allusion to that in his questions. What is your perspective on that question, sir?

Dr. SYED. Thank you very much. I—with regards to data and collecting more data to improve patient health, there are some things that I feel, as a doctor, I could speak to.

When we are talking about improving health, I am thinking about, if we know medications are critical to improving health, we should not let patients walk out the door without their medications. Like, if we know that heart disease is the number-one killer in the country, then we should have cardiologists working hand in hand with the primary care doctors. And if we know that a major part of improving health is overcoming the barriers to the care, then we should have social workers integrated into the care teams.

I think, rather than collecting more data, we should kind of relook at how care delivery is happening right now in the country. And to what someone else said earlier today, you know, if we know that doctors are getting burnt out from doing all the nondoctor work, we should have the care teams take over all the administrative duties and just let the doctors be doctors.

Mr. DUNN. So I—and let me say I like that answer very much. It certainly would have made my life a little easier the last 10 or 15 years.

You shared a story about uncontrolled diabetes, I believe, in your father.

Dr. SYED. Sure.

Mr. DUNN. And I think that you would agree that data helps with that. But also, it is that personal time you spend with them,

saying, “Let’s work with each other, and let’s do the right things.” In other words, it is really a relation step with the doctor-patient relationship. Would you agree with that?

Dr. SYED. Absolutely. I think about—yes, absolutely. I think about a patient I had with morbid obesity. And because of the flexibility with the Medicare Advantage program, I was able to see him as often as I needed to see. And I was more of a health coach than I was a doctor for him. And I was able to—in 6 months I was able to see him 7 times and get his weight down from 250 to 220 pounds. In my previous job, I couldn’t even see him more than twice a year. So that is just the difference. It is a different, completely different, approach towards delivering on the care.

Mr. DUNN. Certainly—our time is about over here—I was saying I certainly appreciate that. I agree with you.

In Florida we experimented with sort of a hybrid Medicare Advantage/Medicare fee-for-schedule, so—the specialists and the primary care, working together.

But I thank you for your comments, I thank the witnesses, and I thank our chair and ranking member, and I yield back.

Ms. ESHOO. The gentleman yields back, It is a pleasure to recognize the gentleman from Maryland, Mr. Sarbanes.

You have 5 minutes to question. Great to see you.

Mr. SARBANES. Yes. Thank you, Madam Chair. I want to thank the witnesses for being here for this important hearing.

I deeply share the concerns of my constituents and those at our hearing today about the impacts that the coronavirus has had on communities of color. I believe Congress should use every available tool—and equitable recovery as well as address the root causes that have created health disparities for years.

For too long, the Federal Government has failed to adequately recognize and address structural racism as the public health crisis that it is. Black and Brown communities have been denied access to quality, affordable healthcare, have faced barriers to securing safe, quality, affordable housing, and have suffered the consequences of environmental racism for generations.

The COVID-19 pandemic, as we know, unveiled and exacerbated longstanding racial disparities in health outcomes. It is time we recognize and treat structural racism and police brutality through a public health lens when we can.

Under the Biden administration, the CDC has begun this work by declaring racism a public health threat and committing to addressing racism in the context of health equity. I commend the CDC for this step, and we in Congress are committed to assisting in the effort. One way to do that is by passing the bills we are discussing today, including the Anti-Racism in Public Health Act and the Social Determinants Accelerator Act.

The Anti-Racism in Public Health Act is a critical bill introduced by my colleagues, Representatives Ayanna Pressley and Barbara Lee. This bill would expand Federal research and investment into the public health impacts of structural racism, require the Federal Government to proactively develop antiracist health policy, and take a public health approach to combating police violence. Among other things, it would create a national center for antiracism at the

CDC, which would award grants to study the health impacts of structural racism.

Dr. Walker, I wanted to turn to you to elaborate on this a little bit. What is the significance of the CDC recognizing racism as a public health issue?

Dr. WALKER. There is clear evidence that racism creates a public health threat, and it creates not only immediate stressors but also long-term health effects that we need to combat.

But many of those factors are ones that we have talked about: the social indications around housing, around transportation, around can you just get access to the care that you need?

We know, for children and adolescents, some of those factors are around mental health access and needs, and resources in schools. And so having the ability to really provide Federal resources to make sure that States and local communities can invest in these factors and increase the ability to address it at a community need base, on those priorities and those areas of local context, are important for us to be able to incentivize health and well-being at the most local level.

Mr. SARBANES. Thank you very much. And I am sure you would agree that gathering up research and data in this space, and having that inform this perspective on the health impacts of structural racism, is also a key undertaking.

What significance would it have to establish a national center for antiracism to serve as a resource hub to share information at the Federal, State, and local levels, in your view?

Dr. WALKER. I think that the benefit is that we could make sure that there is some data standardization but also expertise that often is not accessible in State agencies. So having a national center can lend technical support, can lend some data standardization, but also can support—and collaboration with academic partners in State and local data. And I think having those resources come together in a national center can be very beneficial and can't necessarily be done 50 times over in other areas. And I think that is a—national center, we have worked with them in the past and I think can be a great resource.

Mr. SARBANES. Thank you.

Ms. Blauer, at Johns Hopkins—and let me just say how proud I am, being from Baltimore, about the great work that Johns Hopkins has done, particularly gathering critical data during the pandemic, and the university's Coronavirus Resource Center, as we all know, was a trusted source of information for so many people over the past year.

Could you expand on the role data played in responding to the pandemic, and what additional data and resources might have been helpful, particularly to respond better to the challenges faced by communities of color during the pandemic?

Ms. BLAUER. Yes, thank you, Congressman. I can say that it wasn't until several months into the pandemic response in our work that States even started to release COVID data, demographic data that was rich enough for us to even validate, the kind of front-line anecdotal information we were getting about the disproportionality that that virus was having on residents.

And it has taken us a long time to even get any kind of guidance around demographic sharing of data. We are still only at the CDC reporting around 60 percent of demographic data for the cases and the deaths of people that have been impacted disproportionately by the virus. We are still operating, certainly, in an environment of confusion when it comes to the disproportionality and the effects. And so having some guidance and some standardization around demographic data is so vital as we continue this last mile of work around COVID, but certainly as we think about how we look at the social determinants of health, and the role that data plays in deepening disparities and exacerbating bad outcomes for people. Thank you.

Mr. SARBANES. Thank you, I yield back.

Ms. ESHOO. The gentleman's time has expired. The gentleman from Georgia, Mr. Carter, you are recognized for your 5 minutes of questions.

Where are you?

Mr. CARTER. Thank you very much, Madam Chair, and thank—

Ms. ESHOO. Are you in the car?

Mr. CARTER [continuing]. The witnesses—

Ms. ESHOO. Are you in the car? Where are you?

Mr. CARTER. No.

[Laughter.]

Mr. CARTER. I am in the hearing room.

Ms. ESHOO. Oh, good, OK. I am glad you got out of your car.

Mr. CARTER. I am, too. Thank you, Madam Chair, and thank the witnesses for being here. Very important subject matter.

Dr. Batra—I apologize—and Dr. Syed, Medicare Advantage plans have more than doubled enrollment over the past decade, and these plans clearly offer beneficiaries greater benefits and care versus traditional fee-for-service plans. And this is good. This is a good product that, obviously, is being utilized, and I am glad to hear that.

My question, Dr. Batra, is this: How would beneficiaries benefit by Medicare Advantage plans offering new and existing breakthrough technologies and devices that are FDA-approved but do not fit into an existing benefit category for certain targeted populations, like those with chronic conditions?

Dr. BATRA. Yes, we—I think what we have done consistently is look at, as these new things become available, what has shown proven evidence, what has shown to prove—help with the needs of the membership that we serve. Wherever we have, you know, guidance from Medicare, either through their NCDs or LCDs, we follow those guidances. Where we don't have guidance available right away, we look at other data sources, other peer-reviewed studies, other evidence-based sources, and see if we can fit the need of the population and go from there on.

The other thing that we have done and encouraged in our members is, as things become available, some of them are in the experimental trial phases, which is available through them—to them through Medicare trials.

Mr. CARTER. I don't mean to interrupt you, but I indicated if they were FDA-approved.

Dr. BATRA. Oh, they are FDA-approved, and we do have the flexibility in evaluating what is available, in terms of evidence, and then considering them for the right populations.

Mr. CARTER. OK, and you have a review process for that, whereas you review it among your yourselves—

Dr. BATRA. Yes.

Mr. CARTER [continuing]. And decide whether it is going to be covered or not?

Dr. BATRA. Yes, we do have medical policy departments that work together alongside our provider partners, working very closely with our provider partners, alongside experts—some of them are academic experts—to review them on a case-by-case basis, to look at the needs in a population, to look at what else is available, to look at the comparative effectiveness. So multiple factors play a role in that.

Mr. CARTER. OK. Dr. Syed, what about you? What about your company?

Dr. SYED. Our—we understand that more than 70 percent of modifiable health outcomes are actually based on a preventive lifestyle, lifestyle interventions. So when you have a system that is focused on prevention and the doctors are allowed to focus on prevention, then the patients are more safe at home rather than going to the hospitals. It eliminates all the medical costs, actually, before they even occur. You know, we focus on improving health and reducing suffering through preventive and early interventional measures.

If there is an FDA-approved treatment or a product that can help benefit the patients, then, as long as it is FDA-approved, then we would evaluate that on a case-by-case basis.

Mr. CARTER. Do the individual patients have some type of appeal process, some kind of prior approval process, or anything through your company?

Dr. SYED. I—that I am not—in the full risk model, I am not aware of having to go through that type of process.

Mr. CARTER. OK, all right. Let me move on.

Dr. Batra, again, I serve a very rural community, and many of my constituents have trouble getting to physicians for care. Even during the past 6 months, many of these same constituents could not access vaccines for extended periods of time. It appears that SCAN Health Plans have been recognized as a leader in getting COVID vaccines to homebound and rural patients. Can you share with us what you all are doing to—that maybe other plans could duplicate to improve access to care for beneficiaries in rural communities?

Dr. BATRA. Absolutely. We absolutely follow the principle of leave no older adult behind. So, right from the very beginning, as the vaccine was being developed, we put all hands on deck on figuring out how do we get the right people to the right places. Those who could drive, how do we get them there, give them information, and those who could not get there, how do we get them rides to get there?

But we also serve a large swath of people who are homebound members, who have caregivers taking care of them. So we worked very closely with an organization that then deploys paramedics in

people's homes that could carry the vaccine in a safe way, had oversight provided by nurses and physicians. We were able to schedule those visits for them. And within the comfort of their own home, under watch of a paramedic, as well as the oversight of a nurse, we were able to deliver those vaccines in people's arms. To date we have done several hundred of those, and we will continue doing that with the goal of leaving no older adults behind.

Mr. CARTER. Well, I just want to compliment you and thank you, for your service to the rural communities, in particular, is extremely important. So thank you.

And I will yield back.

Ms. ESHOO. The gentleman yields back, and now another one of the doctors on our subcommittee, Dr. Ruiz from California.

You are recognized for your 5 minutes of questions.

Mr. RUIZ. Thank you, Chair. This is so important. Finally, it is a premed dream come true. You see, back in the 1990s, when I was premed and in medical school, those of us who understood social determinants of health would shout it out in lectures. We would talk about it in the halls of the different academic hospitals. And everybody was so singularly focused on the specifics of medicine, that they didn't really understand.

And now we are actually having a hearing on how to improve data collection for social determinants of health and our public health system. This is groundbreaking. This is incredible. This is the spear of much more to come, the tip of an iceberg.

And I am so proud of Congressional Hispanic Caucus member Nanette Barragán and all the other members of our committee who have pushed forward great legislation to finally get our social determinants of health in the limelight, so that we can really take a comprehensive look at health.

It is not just the absence of disease. It is the ability to enjoy one's life and have wellness and fulfill our human potential in our communities. And from breathing in the toxic air around the Salton Sea in my district, to working in the fields, the grape fields, the bell pepper fields under the blazing sun, to food insecurity, I have seen firsthand in my district how social determinants negatively affect my constituents and my patients—I am an emergency physician, by the way—my patients' health.

So many of my constituents do not have access to healthy foods, whether that is because they live in a food desert or because healthy food is more expensive. Ironically, the same farm workers who pick the healthy foods can't afford those healthy foods at this—sometimes, or they do not have adequate health insurance.

So no matter what the reason is, all these factors contribute to higher rates of underlying chronic diseases like obesity. In fact, nearly half of Black and Hispanic Americans are living with obesity, and this puts them at greater risk of 200 serious diseases, including serious conditions like diabetes and heart disease and serious complications of COVID-19.

This is why I joined several of my colleagues in introducing H.R. 1577, the Treat and Reduce Obesity Act, which would increase access to effective treatments for obesity. Bills like the Treat and Reduce Obesity Act, as well as several that are under consideration

today, will help us address some of these social determinants of health straight on.

And while it is critical to address the social determinants of health in order to improve the health of all Americans, we cannot do that without really understanding the problem. And to really understand the problem, we need adequate, accurate, and timely data that describes the social factors that impact health outcomes like economic status, access to transportation, access to healthy foods, educational attainment, housing, and environmental influences on health.

This data has been challenging to procure in public health, in part due to a number of barriers that range from inadequate design of systems like electronic health records to the use of phone survey systems and a lack of trust for those being asked about their social risk factors.

Dr. DeSalvo, can you speak more on the importance of collecting health quality data on the social determinants of health, and then how to translate that into actual policy and public health programs?

Dr. DESALVO. Congressman, let me just first say I woke up with that same enthusiastic pep in my step today. This is, like, 20 or 30 years of work, and all the data, equity, and public health together and the social determinants are just the things that I care so passionately about. So I appreciate your enthusiasm and really look forward to working with you and others as we bring this to fruition.

Maybe I will just hearken back to my experiences in New Orleans, since you mentioned obesity, and say that when I was the health commissioner, one of the first—when I went two blocks down the street from my medical school, where I was faculty, and took the helm of the health department, I had in my head all the information from the quantitative survey data I had seen saying that cardiovascular disease and cancer were killing the people in my community. And I needed to focus on that.

Within the first 5 minutes of the first coffee I had in a church hall, they said, “Our priorities are violence, mental health, and economic opportunity.” And it was a real mind shift for me, of really respecting and appreciating that the data I might see that is quantitative and collected in some ways doesn’t always reflect the now and what is on the mind of my community.

And so mixing qualitative and quantitative is important. We can scale that by leveraging novel data sources. I mentioned earlier search symptoms trends that public health could use. It is anonymous and can give them a snapshot of their community.

But I took those lessons from them, and I looked at a through line and realized that fitness, obesity, lack of nutritional fitness were contributing to cancer and cardiovascular disease. And as I talked to them more, I realized they needed sidewalks, playgrounds, access to healthy foods. We had to work with our economic department to get grocery stores to go in communities. We had to work on school lunches. Kids designed it, told us they wanted—you know, how they wanted the salad, what would drive them to go away from french fries and pizza, and have some other healthy food. We did it with kids, not for them.

So I think what—once you have the data in front of you, quantitative and qualitative, local leaders can bring people together, and that community can make decisions about how to make interventions and measure success, so we can know what works and continue on that generational trajectory of improving health.

Mr. RUIZ. I love it. Thank you all for the work you do.

Ms. ESHOO. The gentleman's time has expired. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chair.

Ms. ESHOO. You have—minutes for your questions.

Mr. BILIRAKIS. I appreciate it. Thank you. Thanks for holding this very important hearing. Madam Chair, data drives decision making, as you know. And the integrity of these decisions lies in the integrity of the data.

As you know, I am from the great State of Florida, and Florida's COVID-19 story is one of success driven by reliable data and following the science. I have included a press release exposing myth versus fact regarding Florida's COVID-19 data. And I ask unanimous consent that this be entered into the record, Madam Chair.

[Pause.]

Mr. BILIRAKIS. Madam Chair?

Ms. ESHOO. Did you hear? So ordered.

[The information appears at the conclusion of the hearing.]

Mr. BILIRAKIS. Yes, I—OK, thank you. Yes, I didn't hear that. Thank you.

Dr. Walker, Representative Blunt Rochester and I introduced the bipartisan Collecting and Analyzing Resources Integral and Necessary for Guidance for Social Determinants Act, and it is H.R. 3891—excuse me, 3894. And what it does is it provides regularly updated guidance to States to address social determinants of health under Medicaid and CHIP, building upon the success that some State Medicaid programs have already had since testing innovative delivery and payment models.

Additionally, several members of this committee are championing the Social Determinants Accelerator Act, which is H.R. 2503, which would help States and communities devise strategy to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid.

So my question is a couple of questions. How might HHS do more to coordinate social determinant efforts, even without additional congressional authority?

And then also, could you explain how HHS could use its leadership in Medicaid to more broadly catalyze efforts to better coordinate and measure the impact of resources and initiatives that address social determinants of health?

And this is for Dr. Walker.

Dr. WALKER. Thanks, Congressman, for the opportunity to address this question.

It is absolutely critical to think about how to refine ongoing guidance to States around how to address social determinants of health. We know these impacts continue to evolve, and so, even when I was State secretary of health and social services, it was extremely helpful to have this updated guidance provided. It informs waivers, it informs how you can think about State plan amendments. And

as you mentioned, it doesn't require, necessarily, additional authority but gives clarity around where existing resources can be deployed and used most efficiently.

And there are several models out there. So another strategy could be that models like that at the State level are incentivized through CMMI or other waiver authority like North Carolina's.

I expect we will continue to learn from these models, so having evaluations and the data available can be incredibly useful but also providing resources for technical assistance, updated guidance, and examples are tremendously beneficial. Thank you.

Mr. BILIRAKIS. Thank you. And the next question is for Dr. Batra.

Recently I introduced H.R. 4074, the Addressing Social Determinants in Medicare Advantage Act, which increases flexibility for Medicare Advantage to offer supplemental benefits that would help address social determinants of health. Can you discuss how supplemental benefits have improved the lives of your members and how adding benefits that address social determinants of health in Medicare Advantage and broadening beyond just those with specific chronic conditions would mitigate social inequities and allow plans to assist even more members in need?

Dr. BATRA. Absolutely. I have shared with the committee before, we really appreciated getting that flexibility. Post that flexibility, we have designed multiple, newer benefits. I mentioned our benefit called Return to Home around medications, care coordination, and in-home caregiving. We also introduced benefits like respite care for our populations who have caregivers who could use that kind of help, so we use benefits for that.

Beyond that, we extended our meal benefits to provide meals for our folks suffering from chronic conditions, who perhaps need that meal for their diabetes or need a meal for their end-stage renal disease that is appropriate for the condition, so they can have a better food lifestyle in order to improve on the chronic conditions.

So those are a few high-level benefits that we introduced. We have seen, based on our—either both the utilization adoption data as well as our outcomes data when we look at our utilization from ER visits, or admissions or improvement in diabetes control and improvement because of those kind of benefits.

We continue looking at more benefits. And as I had shared with the committee, I would love to have benefits based on your social needs or just based on your medical conditions. Right now we do have the flexibility, but they are still tied to chronic conditions like diabetes or heart disease or cardiovascular disease or chronic kidney disease. But we know, as I shared, we have about 20 percent of our membership that has, at one time or the other, shared with us they have food insecurity. We would be able to do more if we were able to address the needs of a larger population, not limiting ourselves just to chronic conditions. Thank you.

Mr. BILIRAKIS. Thank you.

And I just want—Madam Chair, this particular bill, H.R. 4074, I filed it, due to timing, alone. But I welcome bipartisan support, both in this committee, Ways and Means, and any Members that want to—I think this is a very important issue for the constituents.

Thank you, and I yield back. Thank you for the extra time, Madam Chair.

Ms. ESHOO. Yes. The gentleman yields back. It is a pleasure to recognize the gentlewoman from Michigan, Mrs. Dingell, for 5 minutes of questions.

Mrs. DINGELL. Thank you—

Ms. ESHOO. Right there from the very beginning, and taking everything in. And I think we hear more bounce in your voice, so you are feeling better.

Mrs. DINGELL. We are getting there, slow but sure.

Ms. ESHOO. Good, good.

Mrs. DINGELL. Thank you, Madam Chair—wonderful—and Ranking Member Guthrie for convening this hearing to discuss legislation to address deficiencies in public health data and technologies, which I really care about.

As our witnesses have mentioned, the HITECH Act and funding have led to improvement in data collection that have helped drive better outcomes for patients in the clinical settings. However, while we have seen additional resources directed at gathering and disseminating actionable public health data during the COVID-19 pandemic, longer-term reforms are needed to address these gaps in our public health data infrastructure.

Additionally, doing so will allow us to better direct healthcare resources towards areas of greatest need to better address deep-seated inequities in disadvantaged communities or populations. And I love seeing Dr. Ruiz excited, so I want to get him the data he needs to be able to do that.

But my questions are for you, Dr. Batra, because it was good to see you highlight the Independence at Home program in your testimony. IAH ensures Medicare patients can maintain their independence while meeting their unique medical needs and lowering costs. And I was glad to part with my colleagues on this committee as part of a bipartisan effort to successfully reauthorize and expand the IAH program at the end of last year.

Dr. Batra, you also mentioned that voluntary health risk assessments used to identify members' health needs have a 35 percent response rate—not very good—with a completion rate of 80 percent for special need plan members. What barriers do you see in raising response rates for these assessments?

Dr. BATRA. Absolutely. Right now, the way we do these assessments are either over the phone or through mailing. But you are absolutely correct. We could do more.

We have a significant membership that is aging in and joining MA plans, including ours. For them we have to be ready to provide an online assessment, if that is the way they want to engage with care. So that is one area that we are exploring.

The other area that we are also exploring is for folks who perhaps are homebound, have caregivers who are really busy doing other things and not have the time to fill out the assessments, or they are not available themselves—of assessments. So could we go into their homes and help do those kind of assessments to get a better idea on them? That is a second way of doing it.

The other things that we are also exploring is building out these assessments in different languages. We are based out of California.

We serve a diverse population that speaks many different languages. We right now have assessments that are available in three to four languages. We need to address the needs of our population. We really have to expand those languages, as well, so we can really get feedback from all of our members, not just some of our members.

So those are a few areas that we are thinking about.

And then finally, you know, our providers also do a lot of assessments, and we are looking at interoperability to say, hey, where we do not have those assessments, perhaps our providers have it. How do we get that data and build it in our system, so that we have a more holistic understanding of our population?

Mrs. DINGELL. So let me follow up on that—and I am going to run out of time, so I am not going to be able to ask all my questions—but how do nonresponses and other gaps in data affect your organization's ability to provide targeted intervention to seniors based on social determinants of health?

Dr. BATRA. It does make a big difference because we—generally, when we get this data, that is where we act on. We have an algorithm to say who is going to reach out, who should be offered certain programs, who should be enrolled in certain services. So we are always looking, how can we make our data more comprehensive and robust?

And our approach has been to work with our providers to see how we can further make that data more comprehensive.

Our approach also has been, how do we engage with caregivers? Perhaps they are also the people who can help us in getting those assessments completed.

How do you work with community-based organizations? Looks like Meals on Wheels that perhaps are going in people's homes, and get data from that perspective.

So we are trying to look from everybody who is available at the community level, at the individual level, at the provider level, at the delivery system level to make that data complete.

Mrs. DINGELL. OK, so I am going to rush a question. So missing, incomplete, or nonstandard public health data is more common than anybody would like, particularly when it comes to long-term services and supports as well as other services utilized by our Nation's seniors, which I care deeply about. And I was a caregiver. Yes, I could have filled it out better than anybody.

But how would uniform public health standards, like those in the Health STATISTICS Act before us today as well as improved quality measures for LTSS, improve your organization's ability to meet the need of older adults your organization serves?

And you have 1 second.

Dr. BATRA. Absolutely. We do have a fully integrated dual eligible specialties plan, so we do offer those long-term services and supports. We absolutely believe in the importance of it. And so we are working with in-home community partners, caregivers, formal and informal, in completing the data.

Mrs. DINGELL. OK, thank you.

I yield back, Madam Chair.

Ms. ESHOO. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Utah, Mr. Curtis, for your 5 minutes of questions.

Mr. CURTIS. Thank you, Madam Chair. I am pleased to be here today.

Dr. Batra, my bipartisan legislation coled by my friend Mr. Cárdenas that we are discussing today aims to give private individual market health insurance plans more flexibility and incentive to spend money focused on improving patient outcomes. It does this, specifically, allowing plans to count social determinants of health expenditures toward the Affordable Care Act's medical loss ratio requirement. Services could include partnering with ride sharing companies to help beneficiaries to get to and from appointments, or even paying for groceries.

While SCAN is a Medicare Advantage plan not in the individual market, could you explain how insurance plans are engaged in providing social determinants of health services to beneficiaries?

Dr. BATRA. For us, as a MA plan, we design our benefits based on the supplemental benefits that are made available. One more time, they are made available based on the chronic conditions that they have. If you look at our ongoing data and look at opportunities to close gaps in care, whether they be social gaps in care or, in some context, it may be even medical gaps in care, like affordable medications or access to telehealth vendors, so our approach of planning and designing benefits is based on that approach, and also offered through the Congress giving us the flexibility to design these kind of benefits with social needs as one of the drivers.

Mr. CURTIS. So that plays right into my next question, which is what can Congress be doing to help offer incentives to help you do your job better?

Dr. BATRA. In my mind, offering these benefits in a more holistic manner will really help us a lot.

So right now, the benefits, one more time, are based on your medical condition, which we know is the driver for 10 or 15 percent of your overall outcome. If we were able to design those benefits based on your social conditions—perhaps you are housing insecure and do not have other chronic conditions that may have qualified you for a benefit—that would be one idea for us to do it.

And also thinking of populations that perhaps are not completely fitting into the MA mold, so people experiencing homelessness—could we offer them some differentiated benefits, based on their social needs versus just their medical needs?—is another one that comes to my mind.

Mr. CURTIS. That is good. Thank you. Could you comment on this—along those same lines, would it be helpful to remove some of the barriers such as reforming Stark Law, and could that enhance care coordination between providers, increasing savings for the patients?

Dr. BATRA. It is always great, and being a primary care physician, the more we can collaborate and coordinate with the primary care physician—not only just the primary care physician, but their teams, and their extensions of their teams, whether it be in the hospital setting, or be it in the ER setting—we are always looking

at opportunities to do more of it, whether it be through the data exchange or it be through our teams or working closely together.

Mr. CURTIS. Thank you.

Dr. DeSalvo, could you talk for a minute about how Google is partnering with healthcare systems or insurance plans to gain a stronger understanding for healthcare trends in certain communities or within patient populations?

Dr. DESALVO. Thank you for the question, Congressman. I think one of the opportunities that we all have has come up in the hearing, and that is how can the data that is already available be more intuitive, more accessible, easier for the doc or nurse to find right at the bedside or in the clinic.

Also, for the patient, how do we minimize or reduce the need for them to repeat over and over again what their medical conditions are or, in the case of social determinants, to have to prove they are hungry or unhoused over and over again? What are the ways that we can be more efficient and effective with the data that we are already collecting?

And so, in that context, Ascencion Health System asked if Google could be helpful to apply that notion of making the electronic health record data easier to find and make it more intuitive for doctors when we are trying to make sure we can not only get through the day with our patients but be able to spend time looking them in the eye and not looking at the computer.

Mr. CURTIS. Yes.

Dr. DESALVO. So that is an example—

Mr. CURTIS. If—

Dr. DESALVO [continuing]. Of how we are working on data.

Mr. CURTIS. I am going to jump in on you, simply because we are—

Dr. DESALVO. OK.

Mr. CURTIS [continuing]. So short on time. Talk to me for just a little bit about privacy of this data, and how do we put patients totally in charge of their own data and still reach our interoperability goals?

Is blockchain technology—what technology is out there that we can be thinking about to give patients total control over their data?

Dr. DESALVO. Oh, thank you. Thank you for raising that, because, first and foremost, people do need to understand how their data is being used. That is the transparency piece. They need to have choice about who is going to get it and then control across the journey, something that I spent a lot of my career working on.

And in fact, as we have talked about earlier today, 21st Century Cures pushed this idea of APIs, doorways to the data that consumers control. So it is a great example of how consumers have the control of saying, “I want this data, and I want to share it in—with these trusted healthcare partners,” for example. All of that would fall under HIPAA and with consent, so that the notions are already there and the systems are building.

And the last administration, in the interoperability rule, further pushed this idea technologically, raising an important additional concept, which is, are there ways that data isn’t all stored in one place and that it can be visited or borrowed in the moment, when

the person is either critically ill, having a heart attack, or when you need to use it for more long-term diabetes care?

For pretty early in the journey of knowing how tools like blockchain will work, though, there are many in the healthcare system, in the healthcare environment, in the technology environment trying to understand it.

I just want to emphasize the point again that consumers do——

Ms. ESHOO. The gentleman's time is——

Mr. CURTIS. Yes, I am so sorry.

Ms. ESHOO. It has expired, I am sorry.

Mr. CURTIS. Yes, Madam Chair, I yield my time. Thank you.

Ms. ESHOO. OK, thank you.

Mr. CURTIS. And I hope we can explore that in more detail later.

Dr. DeSALVO. I would be delighted to.

Ms. ESHOO. Good. It is a pleasure to recognize the gentlewoman from New Hampshire, Ms. Kuster.

Ms. KUSTER. Thank you very much, Madam Chair, and thank you for bringing us together today to discuss the opportunities and legislation to bolster equity within public health. Today's hearing is timely, as we continue to safely reopen our economy from the grips of the COVID-19 pandemic and examine many of the underlying health inequities that existed before COVID.

I have often said that this pandemic pulled back the curtain on so many health inequities and injustices, and it is critical for this committee to identify and advance legislation that will support the healthcare delivery and public health approaches for these impacted communities.

One of my main focuses in Congress has been addressing health access issues in rural communities, which are oftentimes underserved and underresourced, to address their unique health challenges. We need to take a comprehensive approach to tackling this problem, which includes everything from expanding primary care options to increasing access to fresh foods and produce.

The existence of food deserts represents a real challenge for our rural communities that is directly linked to worse health outcomes for rural Americans. Without access to fresh food, Granite Staters who live in food deserts may be at higher risk of diet-related health conditions such as diabetes, cardiovascular disease, and obesity.

So that is why I am so pleased that today's hearing includes legislation sponsored by my colleague and good friend, Congresswoman Cheri Bustos, the Social Determinants Accelerator Act, which I am also proud to support. Economic and social conditions such as stable housing, access to transportation, and healthy food have a significant impact on public health and wellness, and this legislation will help States and localities devise strategies to leverage existing programs and boost health outcomes.

So my question is for Ms. Odom Walker.

Ms. Walker, your testimony touches on this bipartisan legislation and the positive impact it will have on health infrastructure investments. Can you expand on this and discuss how this legislation will help rural communities address health disparities and negative social determinants of health?

Dr. WALKER. Thank you, Congresswoman, for the commitment and need to elevate issues around inequities. And there is an inter-

connection between how we look at health and all of the social factors that influence our health outcomes.

Being able to accelerate what works and do more of it, along the lines of creating partnerships between Federal, State, and local agencies is important. And we know that, in the light of the pandemic, that those interconnections were even more important. The inequities were highlighted.

And so having the ability to provide technical assistance and resources to make sure that we are doing more of what works and focusing on the communities of greatest need, it is critically important. We know that those technical resources aren't always available, and having the data, having the know-how to really move beyond what is kind of being done would promote health more broadly. Thank you.

Ms. KUSTER. Great. Well, thank you. Now, your expertise is children's health. And I appreciated you highlighting the intersectionality of children and maternal health. Can you discuss some of the specific challenges that parenting women face in rural communities?

And how can this committee advance meaningful legislation to tackle the underlying negative social determinants for new mothers and their children?

Dr. WALKER. Absolutely. I think, again, it shows in the midst of the lifelong journey of health that health starts preconception. It starts during a healthy pregnancy. And the health of mothers is linked to the health of their children. And rural communities often don't have those same wraparound services but could be supplemented by home visiting programs and other factors, other supports.

We know that factors like trauma and stress of the mother, even before conception, can impact the life course of the child well into adulthood. We need to make sure that there are resources for addressing maternal depression, and some of that could be supported through telehealth supports even if local resources are not available.

But I think some of these other factors around nutrition and how we really think about creating that support impact both cognitive well-being and others. So trying to figure out how to deploy some of it through telehealth resources as well as local community resources can be a benefit, particularly in rural communities.

Ms. KUSTER. Well, and thank you for your reference to telehealth, because often transportation is a real barrier to access to healthcare.

And with that, on the stroke of zero, I will yield back to the chair. And thank you so much.

Ms. ESHOO. Excellent, thank you.

It is a pleasure to recognize the gentleman from Texas, Mr. Crenshaw, for your 5 minutes of questions.

Mr. CRENSHAW. Thank you, Chairwoman. Thank you for holding this hearing today. It is an important one. And I want to talk about the variable that we are trying to understand, the social determinants of health. It goes—and going all the way upstream to understand what might be impeding access to care, what is preventing people from living a healthy lifestyle.

So I am glad to hear that our private plans are working on this already. And as I know, many of them are solving problems of nutrition, which is a really critical piece of preventing health issues through food—you know, and one example is through food subscriptions, like Hello Fresh. Many offer rides through Uber or Lyft so they can get access to their doctor.

So first, I think we have to make sure that the government isn't putting barriers in place that would impede private plans from addressing social determinants. And I am glad that my colleagues Mr. Curtis and Mr. Cárdenas have a bill to do just that.

Second, as we think through how to properly integrate these social determinants into our public health plans, I want to make sure we are thinking through social determinants as a piece of the puzzle and not the sole solution to healthcare problems.

Finally, it is important to acknowledge, as we use social determinants to improve health outcomes, some of our most fundamental healthcare programs are still in desperate need of real programmatic updates. And simply integrating social determinants won't get at some of the most critical issues with Medicaid and Medicare, which is the fee-for-service system. So even the most straightforward solutions are really complicated by rules regarding payments and what regulations on what services to cover.

Dr. Batra, my first question is for you. What lessons can the Federal Government take from the private plans on how to properly balance social determinants as they are integrated into our more complicated public healthcare system?

Dr. BATRA. I think the few things to learn from MA plans—and I can speak for my plan—is having a very person-centered view and starting from what matters to the patient. And what matters to the member or patient or beneficiary is access, affordability, experience, and living the life to the fullest. So you have to balance all of them out.

Medications is a big deal for them, so having affordable medications available to them. Access is huge and access getting to the doctor, so that is where social benefits become important to it.

But also, when you cannot get to the doctor, how do you get to access, whether it be through telehealth, or it be in-home health, if required, is another piece of it.

Mr. CRENSHAW. But can we get to that point without actually innovating the process of what we choose to cover?

I mean, you know, without reforming the fee-for-service system?

You know, will traditional Medicare have to create and approved new benefit categories for, you know, those Ubers or that nutritional support? Is that really the most effective way?

Dr. BATRA. That is true, you will have to overhaul it. Like hearing aids, for example, is not a Medicare-covered benefit. So being a primary care physician, dental is so integral to your medical health as well as your overall health—is not currently covered by Medicare. There are other areas. Like, vision is not currently covered by Medicare.

So there have to be certain areas of priority. And given today, where we are—technology can play a lot of roles in some of these areas. As we think about rural areas, for example, telehealth access could be one of them. Similarly, addressing social needs could

be another one of them. And yes, you know, we can deliver food much better now, perhaps, than we could have done a few years back. So those all become core to it.

And you are right, there has to be a balance between social and medical on both sides, I would say. Not only social and medical—

Mr. CRENSHAW. Yes.

Dr. BATRA [continuing]. But functional and behavioral, as well.

Mr. CRENSHAW. Thank you. My next question is for Dr. Syed.

You know, based on your primary care experience, the practice you represent is dedicated to improving primary care for seniors. And I would like to know, would integrating a program modeled on direct primary care, which currently does not exist within our Federal payers like Medicare and Medicaid but would allow for beneficiaries a personal primary care coordinator—would you find that beneficial to improving health outcomes?

Dr. SYED. You know, I find full-risk, full-capitated doctors and direct primary care doctors having much in common. I oftentimes compare our—both styles of practicing medicine. We are both two arrows that have been shot out of the same fee-for-service bow.

Definitely, there is a population of patients that benefit—that would benefit from direct primary care. I believe now there are over 20,000 direct primary care doctors out of 200,000 primary care doctors in the country. So for a set population, I see there being benefit there. But in the world where I live in, my patients are struggling with the basics. We have centers, for example, in St. Louis where more than 90 percent of the patients rely on us to provide them transportation services.

Mr. CRENSHAW. In my remaining time, could you also comment on the question I asked about moving from a fee-for-service to a value-based system and how that is necessary to really innovate and to be able to cover these social determinants?

Dr. SYED. Absolutely. I would like for you all to think about value-based care, or especially the fully capitated value-based care model, as full responsibility, where the doctors, the primary care doctors and the primary care delivery team, assume all the responsibility. If the quality of the care is expensive, it is on the doctor. If—

Ms. ESHOO. Yes, the gentleman's time has expired.

Dr. SYED. Oh—

Ms. ESHOO. I am sorry to interrupt.

Dr. SYED. Sure.

Ms. ESHOO. OK?

Mr. CRENSHAW. OK.

Ms. ESHOO. Thank you.

Mr. CRENSHAW. I yield back my negative time.

Ms. ESHOO. Thank—

Mr. CRENSHAW. Thank you, Chairwoman.

Ms. ESHOO. I now would like to recognize the gentlewoman from Illinois, Ms. Kelly.

And for those that are with us today as witnesses, she really is the mother of the issue of maternal health on our subcommittee.

So, Congresswoman Kelly, take it away.

[Pause.]

Ms. ESHOO. Are you there?

VOICE. It seems like she is having technical——

Ms. ESHOO. She may be having technical difficulties.

Then let's give her a few minutes.

Are you there, Robin?

[Audio malfunction.]

Ms. ESHOO. No, I think there is something wrong with your audio. Maybe they can get it straightened out, and we will come back to you.

I will recognize the gentlewoman from California, Ms. Barragán, for 5 minutes of questions.

Ms. BARRAGÁN. Thank you, Chair Eshoo, for holding this important hearing on advancing equity in public health, and for including my bill, the Improving Social Determinants of Health, as part of the conversation.

I also want to thank my committee colleagues who have cosponsored——

Ms. KELLY. Can you hear me?

Ms. BARRAGÁN. Maybe we can ask her to mute.

Ms. KELLY. Can you hear me?

Ms. ESHOO. If Robin is on—and I don't see you—please mute, and we are going to circle back with you. But there is some background noise, so make sure you are muted, and we will be back to you in a few minutes for your 5 minutes of questions.

You could proceed.

Ms. BARRAGÁN. Thank you, Chair Eshoo.

I also want to thank my committee colleagues——

Ms. KELLY. I don't know what is going on.

Ms. BARRAGÁN. I want to thank my committee colleagues, Representatives Butterfield, Cárdenas, Clarke——

Ms. KELLY. Can you hear me?

Ms. ESHOO [continuing]. Recognizing you now, because we had some audio problems, but—so please mute, so that we don't have your background noise. Congresswoman Barragán is—has her 5 minutes now, and we will circle back to you. OK?

Mr. RUIZ. I will text——

Ms. ESHOO. I hope you can hear me.

Mr. RUIZ. I will text Representative Kelly, and if our—if committee staff can text her and her staff, as well, I think that——

Ms. ESHOO. Well, my staffer is contacting her staffer. It is like, you know, my office calls yours, but it is—so far, it is not working. So I am trying to intervene by just—by saying so.

OK. Ms. Barragán, you can——

Mr. RUIZ. Can we give Representative Barragán a full 5 minutes, due to those——

Ms. ESHOO. I am not taking time out of her time for the interruption.

You can proceed.

Ms. BARRAGÁN. OK, thank you, Chair Eshoo.

I also want to take a moment to thank committee colleagues, Representatives Butterfield, Cárdenas, Clarke, Blunt Rochester, Rush, Kelly, Welch, and Castor for cosponsoring this critical legislation.

The COVID-19 pandemic has had a devastating impact on communities of color. My district is nearly 90 percent African-American

and Latino, and I have seen what the crisis has done to low-income and underserved communities that don't have access to the services they need. Lack of access to transportation, unsafe or unstable housing, and food insecurity put individuals at a higher risk for worse health outcomes. Addressing these social determinants of health is crucial to reducing health disparities, not only during the current crisis but as we work to strengthen our public health infrastructure into the future.

That is why I introduced the Improving Social Determinants of Health Act, which would provide funds to the CDC to establish a program focused specifically on social determinants. It would also establish a grant program for local public health departments to tackle these underlying issues that contribute to inequity.

Dr. Walker, how have social determinants of health contributed to minority health disparities, including worsening health outcomes for those in underserved communities?

And why have these factors made it harder to care for communities of color during the recent pandemic?

Dr. WALKER. I think one of the first things that I recognized when the pandemic arrived in Delaware was that the communities of color would be most dramatically impacted, because they were unable to follow my basic advice of stay home and stay safe. They had to go to work. They had to put food on the table, and they were worried about their livelihood, and staying housed. And I think those are the challenges that we are trying to navigate as you think about social factors: How do we bring them together when issues around poverty and food insecurity all coalesce?

So having resources, technical assistance, data to inform better and more efficient program delivery or community health worker support or linkages would be a tremendous asset, not only to emerge from the COVID pandemic but also to promote better health at local communities to really address the inequities that we have long known existed, so we could start to think about structural racism and the multilevel interventions that need to be developed and addressed.

And we will have to do it collaboratively, with community voices, with stakeholders engaged from the start. Thank you for that question.

Ms. BARRAGÁN. Thank you.

Ms. Blauer, data from the CDC found that African Americans and Latinos were nearly three times more likely than White Americans to be hospitalized with COVID-19 and twice as likely to die from the virus. Factors such as a lack of insurance, limited access to healthcare services, working in occupations in which telework is not an option, and being more likely to face eviction and homelessness in times of economic instability are only some of the reasons these disparities exist.

Unfortunately, there is a lack of complete, accurate, and standardized race and ethnicity data to help paint the full picture. The question is, what existing State and Federal data infrastructure should be used to ensure clinicians and health systems and health plans that are implementing programs to address social determinants of health have accurate and comprehensive data on patient populations who would most benefit from these programs?

And where does the Federal Government need to make additional investments?

Ms. BLAUER. Thank you, Congresswoman. It is a very good question, and it is one that I have been thinking a lot about over the course of the last 17 months.

We still are completely in the dark in really understanding, fundamentally, where populations had major obstructions to even accessing the very basic tools that they needed to navigate this pandemic, like testing and vaccine access. And that is because of the limitations on demographic data that has been paired with the release of COVID-19 information.

So first and foremost, there must be standardization and requirements on how data is collected and how data is shared from local authorities, health departments, State health departments to the Federal Government, and there needs to be an optimization of not only how that data is collected but how that data is broadly shared, so that local policymaking can align to where those needs are, so we can deploy the resources, so that people that are living in communities, particularly those that are disproportionately affected by health disparities, have equal access to the very tools that they are going to need to navigate not only this pandemic but the very real health challenges that are associated with navigating all of the social determinants of health that you have remarked on in your comments today. So thank you for the question.

Ms. BARRAGAN. Thank you so much.

And thank you, Madam Chairwoman, for your patience, given the interruption. With that, I yield back.

Ms. ESHOO. You are most welcome. Now, let's see if our friend Ms. Kelly is—I see her room on the screen, but I don't see her.

Ms. BLUNT ROCHESTER. Madam Chairwoman, Ms. Kelly is in a dual committee, and so asked if I would—

Ms. ESHOO. OK, all right. Then the Chair will go to recognizing the gentlewoman from Delaware, Ms. Blunt Rochester, for your 5 minutes of questions.

Ms. BLUNT ROCHESTER. Thank you so much, Madam Chairwoman, for the recognition. And thank you to all the witnesses for being here today to discuss the important slate of bills at the intersection of data, health equity, public health infrastructure, and healthy outcomes.

I also want to give a special thank you and recognition to Dr. Kara Odom Walker from Delaware. A phenomenal job, and thank you for being here today.

I am also pleased to see two bills from the Black Maternal Health Momnibus Act being discussed today, and I look forward to having my colleagues support our bill, my bill. It is a bipartisan bill, the Moms Matter Act, H.R. 909, which is part of the Momnibus. The Moms Matter Act would make community investments to support moms struggling with maternal mental health and substance use conditions, and also grow the healthcare workforce in those sectors.

We know that maternal mental health is deeply tied to and predicted by the social determinants of health. Given that next month is Black Maternal Mental Health Awareness Month, I hope that the committee will consider this bill and the entire Momnibus.

And Dr. Walker, could you share how—how would improving maternal mental health and the health of mothers impact the lifelong health trajectory of their children?

Dr. WALKER. Thank you, Congresswoman, and thank you for your leadership to our great State.

I have to say that investing in maternal health, particularly around mental health, does have long-term impacts. We know that they are linked. We know that factors that happen early in pre-conception around trauma and stress during pregnancy and early postnatal care that—risk their own lives, but also that of their child. And it is a huge factor in how children develop.

So maternal depression is linked to so many other outcomes for children: their economic success long term, their ability to succeed in school, the likelihood that they will access child care and early education. And I think what we know is that even things around preconception diet all have longlasting impacts.

So if we can really think about the cognitive and behavioral development and the support of moms, making sure that we are looking at maternal depression can ultimately impact a generation, ultimately impact the well-being of the child. And I think what we have seen in COVID is that this issue is more important now, more than ever.

Ms. BLUNT ROCHESTER. Yes. Well, shifting gears, Americans with lower incomes are frequent targets of tobacco industry marketing and often face financial and other stressors that can lead to continued tobacco use.

As we know, tobacco use is a key driver of poor health outcomes and a major health equity concern. Medicaid enrollees use tobacco at more than twice the rate of those with private health insurance. Yet Medicaid tobacco cessation treatment is often less comprehensive than what private health insurance plans are required to provide.

In addition, there are barriers such as copays and sometimes prior authorization or step therapy that can also impact the insurance types.

Tobacco use also negatively impacts our Nation's children. More than half of all children with asthma get their coverage through Medicaid and CHIP, and exposure to secondhand smoke can cause asthma attacks. That is why I was proud to introduce the Quit Because of COVID-19 Act, H.R. 2125, which would expand comprehensive tobacco cessation coverage to all Medicaid and CHIP enrollees. Fundamentally, this bill is really about equity, giving Medicaid enrollees equal access to effective tobacco cessation treatment so that they can live healthy lives.

And as we talk about recognizing and addressing social needs and improving health data systems, I can't help but think of Delaware's leadership as the first State to launch a statewide health information exchange back in 2007, the Delaware Health Information Network, otherwise known as the DHIN.

And so, Dr. Kara Odom Walker, if you could, just speak a little bit about the opportunities to leverage clinical health information networks like the DHIN to strengthen our public health data and public health response to both pandemics and the social determinants of health.

Dr. WALKER. Thank you, Congresswoman. We know that health information exchanges make it easier to exchange clinical information for treatment, care coordination. All of the witnesses have talked about that interconnection. And we are very fortunate to have a statewide health information exchange. This would allow us to really think about an opportunity to expand HIEs' ability and strength to not just look at clinical data, but also how we leverage social determinants of health data, because they are interconnected and they are causal and they really do indicate the need.

We really do need, as physicians, to think about the wraparound indicators around health, not just what is happening in that one-on-one patient encounter but what happens when they are home, when they are at church, when they are in their communities. And I must say that the pandemic has shown us that even more data integration across State lines is challenging. And so having the ability to share information in that way could be incredibly helpful for COVID. We needed that. We needed—

Ms. BLUNT ROCHESTER. Thank you—

Dr. WALKER [continuing]. To create a response across the board.

Ms. ESHOO. The gentlewoman's time—

Ms. BLUNT ROCHESTER. Thank you, Dr. Walker.

Ms. ESHOO [continuing]. Has expired.

Ms. BLUNT ROCHESTER. Thank you, Dr. Walker.

And I yield back, Madam Chairwoman.

Ms. ESHOO. OK, let's see. We need a band to welcome her back. Are you there, Robin? There you are.

Ms. KELLY. I am here. Can you hear me?

Ms. ESHOO. Wonderful, all right.

Ms. KELLY. OK.

Ms. ESHOO. We are thrilled to recognize you for your 5 minutes of questions.

Ms. KELLY. Thank you—

Ms. ESHOO. And all the—

Ms. KELLY. Thank you, Chairman Eshoo and Ranking Member Guthrie, for holding this hearing to discuss how we can improve our public health data infrastructure to advance equity and address social determinants of health.

The COVID-19 pandemic has highlighted the gaps in our public health data infrastructure but also provides an opportunity to better integrate and standardize data collection. Unfortunately, data on race and ethnicity continue to be incomplete across the public health system. This data—these data are critical to identifying and addressing disparities in disease, prevalent healthcare access, and health outcomes. Addressing the social determinants of health is an important way to tackle health disparities.

I applaud Congresswoman Bustos' work on the Social Determinants Accelerator Act, and Representative Pressley's Anti-Racism in Public Health Act. Too often, social determinants of health is used as a stand-in for addressing issues of interpersonal and systemic racism. So it is important to continue addressing racism in public health.

Dr. Walker, how does racism and other structural inequities drive social determinants of health?

And specifically in your experience, how does it affect the health of pregnant individuals and their infants?

Dr. WALKER. Thank you, Congresswoman. We know that social determinants of health matter. And in fact, you know, what we do in a medical setting is—about 10 percent of long-term life expectancy. And for that reason, many have written about it—the National Academy of Medicine.

Even at Nemours we were trying to figure out how to launch a social determinants of health screener to better understand all of the needs of the child. And we do that in pediatrics from day one of life, beyond. But what we know is that some of those predictors actually happen during the maternal period, during preconception, during the pregnancy. And so, if we can incorporate those same principles and strategies earlier on, we will have a chance to promote better health, long term.

Ms. KELLY. Thank you. I would like to submit to the record “Addressing Racism and Socioeconomic Influencers,” coauthored by the National Partnership for Women and Families and the National Birth Equity Collaborative, as part of their Saving the Lives of Moms and Babies series.

Also, Dr.——

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Ms. KELLY. What are the current gaps in maternal health data collection?

Dr. WALKER. We know that we have data gaps, and some of those data challenges are around just having accurate, reliable, standardized race/ethnicity data incorporated and geocoded at the local level. So having data dashboards is critically important. We are, at Nemours, trying to geocode information that we have. But we see differences by race, ethnicity in who reports their own information. And I think that is an opportunity to provide guidance, to provide technical assistance and really think about data standards to make it more informative and more useful, to allow the collaborations between public health agencies and health systems to better represent what is going on, and address those inequities in case.

Ms. KELLY. Is it currently being collected by community organizations or the private sector that will be helpful to integrate with the clinical data, to better understand maternal health risk factors?

Dr. WALKER. Yes, it is being collected, but I think the challenge is that there often are gaps in what we have. For example, we have some information in our health record that isn't necessarily the same as what is in our health information exchange. And so there just is a process of making sure we are using the best data available, that we are using self-reported race/ethnicity, and that we are sharing that same information at the highest quality available with others who are trying to collaborate, and really address inequities.

But it does take everyone. Otherwise, we are without that data and high-quality data. We are—our challenge in trying to overcome the barriers and leaving people out, particularly in communities of color.

Ms. KELLY. Thank you, and I yield back.

Ms. ESHOO. The gentlewoman yields back. I am glad it all got straightened out, and thank you, Robin, you are wonderful.

The Chair is pleased to recognize the gentlewoman from Minnesota, Ms. Craig, for your 5 minutes. Thanks for your patience. We are thrilled you are on the committee.

Ms. CRAIG. Well, thank you so much, Chairwoman Eshoo, and especially for holding this incredibly important hearing today. And thank you to all of our witnesses for being so patient with us and our very many questions, as well.

I appreciate, especially, the focus on the drivers of health disparities: race, ethnicity, sexual orientation, gender identity, and social determinants of health like access to transportation and housing.

I represent a district that is equal parts urban, suburban, and rural. And many folks living outside of the major cities don't have reliable access to in-person appointments with medical professionals. I was recently appointed to serve on the Select Committee on Economic Disparity and Fairness and Growth, where I will have an opportunity to address the economic inequalities faced by rural communities, disparities that have a direct impact on healthcare access and outcomes.

I am also a proud cosponsor of many of the bills up for discussion today, including H.R. 2503, the Social Determinants Accelerator Act. Introduced by Congresswoman Bustos, this bill would create a program at CMS to provide grants to State and local governments to develop plans to combat social determinants of health that are negatively impacting health outcomes.

With that, my first question is to Dr. Odom Walker.

Rural residents in my district face long drive times to the doctor, and lack of high-speed internet. For instance, rural Minnesotans seeking inpatient mental health and chemical dependency treatment must travel three times longer than urban patients, on average. And many in my district have limited to no broadband access, making it very difficult to reach them via virtual healthcare. This lack of access undoubtedly leads to worse health outcomes, and it is not an uncommon story in my part of Minnesota.

How could the Social Determinants Accelerator Act, Dr. Walker, which invests in State and local capacity, help rural communities fight these factors that are leading to negative health outcomes?

Dr. WALKER. Thank you for the question, Congresswoman. I think it is unique, and one of the opportunities with the Accelerator Act is that—you invest at the local level to hear from stakeholders, hear from communities about their particular situation and needs.

For example, maybe a strategy that could be invested is a telehealth kiosk that is at a local entity, a community center, something that is, you know, commonly available, to provide that telehealth and broadband access in a stable way. These are the kind of ideas that some have deployed, but it needs scale. It needs, you know, to do more of it where it works, because just putting telehealth into place doesn't necessarily overcome those challenges. And if you have to drive 3 hours to the doctor, that also is not necessarily addressing the challenges of rural communities.

So really trying to figure out how to make it unique for the community that we are talking about and making sure that we are

looking at the right lens, the right problem, and with the right data is really important in this bill.

Ms. CRAIG. Thank you so much, Dr. Walker. My next question is for Dr. DeSalvo.

I am a proud original cosponsor of the Black Maternal Health Momnibus Act, which includes H.R. 925, the Data to Save Moms Act. One provision of the Data to Save Moms Act would provide funding to promote representative community engagement within maternal mortality review committees, which are multidisciplinary committees in States and cities that perform comprehensive reviews of deaths during or up to 1 year after pregnancy.

Dr. DeSalvo, why is it important to gather a diverse range of perspectives in maternal health data collection and reporting processes, including to the elevation of voices and experiences of people from communities most severely impacted by our Nation's maternal mortality crisis, particularly communities of color?

Dr. DESALVO. Thank you for the question, Congresswoman.

We have an expression in public health that the work needs to be done with community, not to community. And that particular part of the Momnibus package describes that so well, that it is not just about experts looking at the data, people in medicine, or even public health professionals. It has to be done with community to understand what is being seen and how to identify appropriate interventions that are culturally appropriate, linguistically appropriate, and are going to meet the needs of the community.

So that kind of engagement is essential, really, when we are tackling major public health challenges like maternal mortality, which is higher than any other high-income country and rising in the U.S., and particularly acute for communities of color.

So the suite of bills not—really helps us understand. It is quantitative. It is the voice of community. And, as you have raised in the prior question, it is a multipronged approach. It is not just about great medical care. We have to make sure people have access to the social needs being addressed, as well.

Ms. CRAIG. Thank you so much, Dr. DeSalvo.

And with my time expired, Madam Chairwoman, I will yield back.

Ms. ESHOO. The gentlewoman yields back. It is now a pleasure to recognize another one of the new members to our subcommittee in this Congress, one of the five women on the Democratic side of the aisle, the woman from Texas, Mrs. Fletcher.

You have 5 minutes for your questions. Thanks for your patience.

Mrs. FLETCHER. Well, thank you so much, Chairwoman Eshoo, for holding this hearing. And thank you to all of our witnesses for sharing your testimony with us today. It is really thoughtful, really insightful.

Social determinants of health has been an issue that people in my district in Houston have been concerned about, researching, talking about in ways that are constructive and useful. In fact, we had a town hall on this topic shortly before the pandemic, and several roundtable discussions. And so I just really appreciate the perspective that you brought today, because, of course, we have seen during the COVID-19 pandemic that these issues affected out-

comes across the country, as many of my colleagues have already discussed today.

So I think what has been really useful today is making clear to all of us on the committee the need for data to address the deficiencies in our public healthcare system. We have a great slate of bills to really get at that. And I think it is, you know, not just data itself, but more inclusive data that takes into account the social determinants of health, as we move forward.

And so, Dr. DeSalvo, I was really interested in your comments on creating a system with the community to collect data and address social determinants of health. And as we have seen from the COVID-19 vaccine rollout, for example, you know, as of earlier this month, I think June 7th, less than a quarter of Black Americans had received their first shot. And there is a considerable amount of mistrust in the healthcare system among minority populations. And this can be a huge barrier for people getting the care that they need.

So from your experience, how can we collect health data in a way that engages impacted communities to better address their needs?

Dr. DESALVO. Thank you for the question, Congresswoman, and just to acknowledge Houston as a place that has done some great work in multisectoral collaboration. And so you all do know how to address social determinants in a public-private-sector fashion.

With respect to seeing the data and being able to act on it, I will give you some examples that relate to public-private sector coordination and ways, certainly, that we at Google have been thinking about partnering, particularly with academics.

Early in the pandemic it was clear that there needed to be more understanding of how COVID-19 was disproportionately impacting communities of color. We worked with Morehouse, with the David Satcher Institute, to develop a COVID equity tracker that will also be able to now report out on other inequities or disparities in related diseases, like diabetes. So it is an opportunity for us to not only help them with data, but to help build technical capacity that can support public health decision making.

Another more recent example, since you raised vaccines, is work that we have done with the Harvard Medical School and Ariadne Labs, again, to not only provide data insights but provide technical assistance and partner with them so public health departments, healthcare systems can see where there are vaccine deserts. Who needs extra help getting to a vaccine? Should we put up a popup clinic on this corner to reach more people? Those are ways where everybody together can really begin to meet people where they are to get them the services that they need.

Mrs. FLETCHER. Terrific. Well, thank you for that, and I want to move on with the time I have to talk about another issue, which is that many public and nonprofit safety-net hospitals serve large populations of low-income and diverse patients, and they are challenged by numerous social risk factors. And some have come together to share and innovate on best practices. And, you know, I have seen that in Houston, especially—you know, we have a really good collaboration, and I think that is a part of how we do things in Houston. But they often lack data platforms that track both

medical and social conditions and facilitate access to services that respond to those needs.

So, Dr. Walker, in the time I have left I want to talk about your testimony. You talked about the fact that public and community-based organizations haven't been given the same level of investment as other healthcare organizations. Would you agree that investments for data platforms and safety net providers who often struggle under difficult financial circumstances could drive progress in addressing health inequity?

Dr. WALKER. Absolutely. I think data informs strategy. And without that data, we are often leaving people out, leaving individuals and populations out, and have an incomplete picture of where we need to deploy public health resources or make policy decisions, which, underlyingly, has been the challenge with exacerbating disparities.

I think that there is another benefit—in the seconds I have—just to have data available as a common good, instead of having disparate organizations, health systems and others trying to piece it together.

Mrs. FLETCHER. Wonderful. Well, thank you so much.

And I am almost out of time, so I want to thank you again, Chairwoman Eshoo, for holding this hearing. I am so supportive of the legislation that we have covered today, and I am grateful for the chance to learn more from this wonderful panel of witnesses. Thank you so much, and I yield back.

Ms. ESHOO. Thank you. Now I—let's see. Oh, another one of our wonderful doctors, the gentlewoman from Washington State, Dr. Schrier.

You have 5 minutes for your questions.

Ms. SCHRIER. Well, thank you, Madam Chair, and thank you to all the witnesses who spoke today.

Dr. Walker, I am so intrigued by the endless possibilities that data sharing and interoperability offer to improve childhood outcomes. So, from the perspective of a pediatrician, I think, wow, it would be really helpful to know which of my patients qualify for free and reduced lunch at school, because that could help guide me in conversations about nutrition and financial stressors, housing, whether the parents have the bandwidth or the resources to help their kids in school. It would even help me focus on community resources like story time at the library.

It would also be really helpful to know which of my patients rely on WIC and SNAP, since poor nutrition is associated with adverse behavioral and academic outcomes but also with tooth decay. And so I could use that knowledge in the clinic to, say, apply fluoride to all my patients' teeth, as opposed to just hoping that they will follow through and see a dentist.

I would imagine that this kind of information would be really helpful for teachers, as well, to know which of their students are homeless or relying on social services.

So my question for you, Dr. Walker, is how do parents feel about data sharing between public health, social services, schools, and doctors?

Dr. WALKER. Thank you so much for that question, and I often think of the context of families and how, as physicians, we are

often limited by not having the entire picture. And if I knew that a student wasn't doing well in school, in that clinical interaction I could ask whether they have been tested or need to be retested for vision screening or have a hearing test, and whether that is a promoter.

But I do think that the issue of trust in data sharing is a real one, and one that we are always careful in navigating. But with the right support, the right technical assistance, we could make sure that we have the right data analytics in a protected environment and allow us to think about how to do this in the right way, learn from those early adopter States that have already figured some of this out, like Oregon and some that we have mentioned earlier, North Carolina—

Ms. SCHRIER. Right.

Dr. WALKER. And then some of—

Ms. SCHRIER. And I think that brings me—

Dr. WALKER [continuing]. That innovation.

Ms. SCHRIER. Thank you. I think that brings me to my next question for Dr. DeSalvo.

First, I just want to thank you for your work on the app that we use in Washington State that was developed by Google in combination or in partnership with our department of public health so that, if you have got your phone with you and you are near somebody with a positive COVID test, it notifies you.

And so, given that experience with public-private partnerships and with privacy, I was just wondering, when we talk about kind of a relationship between schools and social services and public health and doctors' offices, how do you address privacy issues related to that kind of data sharing that would help patients and would—yes, how would you address the privacy issues?

Dr. DESALVO. Yes, Congresswoman, thank you so much for raising the question. And I will echo what Dr. Walker shared, which is—I am an internist. And always, we want to know more about the home context or the social context to understand if that is what is, you know, driving some of the—uncontrolled diabetes, as an example.

I think what I have learned from not only patients, but what people tell you in focus groups and surveys, and you being—when the National Partnership for Women and Families does surveys, or the—or when we did the—met the office of national coordinator—is people want to know that they can have some sense of knowledge about who has access to their data. That is the transparency part. And they very often—people they trust. They just need to know that they have some control over how that happens.

And the—in this space that you are describing, which—I mean, technically, some of those entities fall outside of HIPAA—there has been a lot of work in thinking about how, as we are going to—as a healthcare system, and a public health system, be more inclusive of data, give consumers that choice and control—

Ms. SCHRIER. That makes sense.

Dr. DESALVO [continuing]. Sharing.

I will just call out the particular place that provides the—that has been doing the thinking on it. It is a group called the CARIN

Alliance, not as in my Karen, but C-A-R-I-N, working with consumers and others to understand content.

Ms. SCHRIER. Thank you. One more question for you. There's a lot of what-ifs about COVID and how we handled it, what could have gone better. And I think about whether, you know, if we had a really modernized, interoperable, digital, wonderful health infrastructure, if we could have used, say, wastewater testing for COVID in order to really direct our public health response, and now we are talking about tracking COVID-19 variants in a—in one of the bills being discussed today. How could an optimally situated public health department use data about new variants to curb spread of disease?

Dr. DESALVO. In a few seconds, just to say what was desperately missing for public health was not only the now, casting the data that Dr. Blauer was able to provide the country, but the opportunity to forecast and be able to predict what—where the virus was going to spread and where variants would spread into the future.

We have partnered to create a system called Global.Health with Global Public Health to begin to advance that work in forecasting. But the bills that you have before you, the kind of work that Congress is doing, is thinking about not just the data but the infrastructure and the people who work on that data around it. So it has got to be a system in order to prevent the kind of outcomes that we had in this last pandemic.

Ms. SCHRIER. Thank you very much.

I yield back.

Ms. ESHOO. The gentlewoman yields back. I am getting a kick out of myself saying “yields back,” because I have let so many Members to go way over. So they really don't have any time to yield back, but we have accommodated everyone. I hate to cut people off, because everything, every question and answer, is just so important to us.

And now, last but certainly not least, a real value-added new member to the committee, the gentlewoman from Massachusetts, Congresswoman Trahan.

You have 5 minutes for your questions.

Mrs. TRAHAN. Well, thank you—

Ms. ESHOO. How about 5½?

Mrs. TRAHAN. The joys of going last, I get a little extra time. No, thank you, Chairwoman Eshoo. And thank you to all the witnesses here today. It has been so informative.

There is no question public health data is multifaceted, and it resides in different agencies and institutions that span across, you know, social services, education, behavioral science, and so much more. And improving data collection and closing those gaps is critical to our not only addressing the ongoing COVID-19 pandemic but all of our other public health challenges.

You know, in 2015 my home State of Massachusetts recognized the value that data innovation has in inadequately—excuse me, in adequately addressing public health crises and passed Chapter 55, a law which authorized the Massachusetts department of health to link multiple, traditionally siloed data sets with insight into the opioid crisis, an approach that had never been before sort of cross-studied. And the reports and underlying analysis drew insight from

a database that linked mental health data, jail and prison data, vital records, you know, substance addiction treatment data, ambulance and counter information, the States' all-payer claims database, and others. And based on all those insights from Chapter 55, the reporting and the data visualizations, measures like limiting first-time opioid prescription to 7 days, a first-in-the-Nation measure, was signed into law.

So in 2017, when opioid-related overdose deaths fell for the State population as a whole, data showed it rose by 44 percent for Black males. And this data led the health department to develop a community-based public awareness campaign to focus on and reach Black men.

So you know, Dr. DeSalvo, I will start with you. Can you just speak once again to how cross-departmental sharing of information can be used to drive policy to combat public health crises in the country, such as the opioid epidemic?

Dr. DESALVO. Yes. Thank you so much, Congresswoman, for reminding all of us that bubbling under the surface is another epidemic that was here prior to the pandemic and is beginning to re-emerge. So we have to, when we are thinking about building public health data systems, we have to remember they need to be useful not only for communicable disease but for other conditions that affect communities, opioids being a great example in Massachusetts, in this case, as in others.

It has been smart about leveraging multiple data sources that tell the story of a person's health or a community's health beyond just the healthcare episode. You are describing data sources that describe there are social and human services interactions, as well as their healthcare needs. And all of that will be necessary, if you are going to take a multipronged approach to developing community interventions to drive equity and address social determinants as well as medical needs and then measure the outcomes, as you describe.

So a takeaway for me from that lesson you all have been teaching the country is multiple sources of data needed to tell the story of somebody's health or needs, and take action in a multipronged way at the community level and know if we are making a difference in outcome. And we need to build those systems to be agile, so they can address the multitude of community needs that are there on the front lines.

Mrs. TRAHAN. Thank you. You know, one other thing that was made clear to me is that, in order to collect robust data to tackle these public health crises, we must heavily invest in both public health infrastructure and workforce in the field of data and informatics.

And over the years, researchers have discovered a large variety of human biases that shows the things that people understand or believe do not always reflect what is actually happening in the real world.

And so, question for you, Dr. Walker: Could you just speak to how investing in a diverse pipeline of individuals and health data analytics can work to mitigate, you know, unconscious bias in the analysis of data that drives our policies?

Dr. WALKER. Thank you for that question. I think having a diverse workforce is—allows you to interpret the data in the right way. But I would also say it is not just about the professional workforce. It is also trying to figure out how to have community and stakeholders involved in that data interpretation stage.

So thinking about piecing together information, whether it is for the opioid pandemic or other inequities, we know that bringing them together is critically important and requires an investment of expertise, but also of what you do with it and how you put it out to the world, whether it is a data dashboard that we found incredibly valuable in the past year and a half, or whether it is putting it in the hands of local community advisory boards who can say whether, for their community, it is more important to have broadband investments or to think about transportation.

So I think it is essential, and we just have to figure out where to—

Mrs. TRAHAN. Yes. Well, thank you. And making that data consumable is job number one, so we know how to act on it.

So I am out of time, even though the chairwoman was gracious enough to give me a little bit more. So thank you so much for all of your input today. It is very helpful in our policymaking.

I yield back.

Ms. ESHOO. The gentlewoman yields back.

Well, we have come to a conclusion of all of this time with Members asking their questions. I want to thank each one of the witnesses.

You have been with us for a long time today, almost 4 hours—20 minutes shy of 4 hours. So I hope you had breakfast, because you certainly have missed lunch.

Dr. DeSalvo, Dr. Batra, Ms. Blauer, Dr. Syed, and Dr. Walker, you have all been terrific.

Now, Members have 10 business days to submit additional questions for the record. So witnesses, we are asking you to please respond as promptly as possible to the written questions that are going to be submitted to you.

And now I want to go to my friend, the ranking member of the subcommittee, Mr. Guthrie, because we have 23 documents to be submitted into the record, and I would like to request unanimous consent, but I need your consent.

Is Mr. Guthrie with us?

Mr. GUTHRIE. Our side consents.

Ms. ESHOO. There you are. Thank you very much.

All right. So there is unanimous consent to enter the these documents into the record, and I think that is it.

[The information appears at the conclusion of the hearing.]

Ms. ESHOO. So thank you, everyone. Bravo to each one of the witnesses. It was a terrific hearing.

And we are going to move these bills. We have 13 today, in this legislative hearing. I think 6—I think there are 6 or 7 that are bipartisan. So we are always pleased and proud about that.

But all of them are a reflection of the very important work of many Members of Congress in writing the legislation and having our subcommittee have the honor of having a legislative hearing.

So God bless all of you. God bless our country. Thank you for being witnesses.

And the Subcommittee on Health will now adjourn.

[Whereupon, at 2:12 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. RICHARD HUDSON

I want to thank Chairwoman Eshoo and Ranking Member Guthrie for holding this important hearing today, and thank our expert witnesses for their time and testimony.

As you may recall, last summer, I requested a hearing on the disparate impact COVID-19 was having on our minority communities, to which this Committee responded and held one. I am pleased we are reexamining this issue, particularly in the context of how we can work toward solutions by examining social determinants of health and the data associated to correctly address the issues raised.

I think we all can agree that minority communities are and have been experiencing gaps in access and health outcomes. This problem has been further emphasized during the COVID-19 pandemic. There is no question that across the Nation, there remains alarming data of the disproportionate impact the Coronavirus pandemic has had on our minority communities.

Fayetteville, North Carolina, in my District, has a large and diverse community. At one point during the pandemic, I heard from leadership at a local hospital, Cape Fear Valley Medical Center that, while African Americans made up 57% of their COVID-19 patients, Cumberland County, where Fayetteville is located, is only 34.9% African American.

These inequitable outcomes are not just isolated to COVID-19. I continue to hear from my District about how the differences and lack of access to medical, economic, educational, and community resources leads to disproportionate outcomes.

Unfortunately, this is not localized to my District—this is a national and global issue, and we must not continue to settle for the status quo.

We must be looking at avenues to address the impact of social determinants of health, including some of the bipartisan bills discussed today.

I would particularly like to emphasize the importance of further enabling and promoting private sector innovation. I believe this can effectively be accomplished by continuing to incentivize public-private partnerships. This is an area I have focused on this Congress, and I look forward to working with my colleagues on this Committee to engage and bring forward bipartisan solutions.

I also agree with many of the witnesses and my colleagues today who have noted the need for more data. Data will help us dive deeper into the issues—allow us to effectively, efficiently, and appropriately conduct analyses, comparisons, and juxtapositions—to better inform not only us as policymakers, but the folks on the ground who are taking steps every day to work towards more equitable outcomes.

With that being said—I also think this data must be collected and examined in modern and responsible ways. We cannot solve this problem by creating additional bureaucracies and duplicative programs. Our health systems already have enough on their plate.

We should ensure the initiatives we are proposing are streamlined and straightforward to implement, particularly in this constantly evolving technological area.

Again, I greatly appreciate the discussion today, and am committed to working with my colleagues on the Health Subcommittee to address healthcare inequality and the racial disparities in our healthcare system.



**Statement for the Record Submitted by
Stacey D. Stewart, President and CEO, March of Dimes
Hearing of the Subcommittee on Health of the House Committee on Energy and Commerce
“Empowered by Data: Legislation to Advance Equity and Public Health”
Thursday, June 24, 2021, 10:30 A.M.**

Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the House Energy and Commerce Subcommittee on Health, thank you for your commitment to addressing the nation’s health equity gap by considering the bills during today’s hearing. March of Dimes commends you for holding this hearing to examine a topic of utmost importance to maternal and child health.

On behalf of March of Dimes, the nonprofit organization leading the fight for the health of all moms and babies, we appreciate this opportunity to submit testimony for the record. We began that fight more than 80 years ago as an organization dedicated to eradicating polio in the U.S., a goal that we achieved. We continue that fight today as we work to address some of the biggest threats to moms and babies, such as premature birth and maternal mortality, through research, education, programs and advocacy.

March of Dimes’ ongoing work to improve maternal and infant health is more important than ever as our nation is in the midst of a dire maternal and infant health crisis. Rates of preterm birth are increasing, the U.S. is one of the most dangerous places to give birth in the developed world, and there are unacceptable disparities in birth outcomes between women and infants of color and their White peers.

We know the pandemic has only worsened this crisis. According to Centers for Disease Control and Prevention (CDC) data, expectant mothers with the virus had a 50 percent higher chance of being admitted to intensive care and a 70 percent higher chance of being intubated than non-pregnant women in their childbearing years.¹ The data also shows pregnant Latina and Black women were infected at higher rates than White women. As we know, COVID-19 strikes the respiratory and cardiovascular systems, which are the two systems already strained during pregnancy.

Pregnancy affects every system in a woman’s body and the immune system changes so that it can protect not only the mother, but the baby. This can make pregnant women more susceptible to certain infections as different parts of the immune system are enhanced while others are suppressed.

We also know, the health and well-being of mothers and infants are inextricably linked. By improving the health of women before, during and between pregnancies, we can improve outcomes for both them and their infants.

This is certainly true when it comes to addressing social drivers of health.

ADDRESSING HEALTH INEQUITY FOR PREGNANT WOMEN

Social drivers of health are health outcomes that are influenced by the environmental factors surrounding an individual.ⁱⁱ These include, but are not limited to, employment, housing, nutrition, education, and access to quality care. There have been studies demonstrating that social drivers are linked to poverty and structural racism,ⁱⁱⁱ and reducing these inequities are critical to the families who live in these communities, especially pregnant women, and policymakers and community-based organizations need to be involved.

March of Dimes is an active national collaborator and partner directly working to advance programs, research and policies to ensure that every mom and baby is healthy regardless of wealth, race or geography. Convening with communities to implement evidence-based strategies that address the social drivers of health to end the healthy equity gap.

The *Mom and Baby Action Network*, led by the March of Dimes, is a national 190 member cross-sector partnership that is working to influence and leverage collective action to lead broad changes in policy, research, funding and systems to address the root causes of inequities in maternal and infant health. Through action-orientated national workgroups, evidence and community informed solutions, this initiative will move five strategies into action; dismantling racism, increasing high quality and value health care, promoting environmental justice, addressing lifelong economic security, and building safe supportive communities.

March of Dimes has developed, *“Breaking Through Bias in Maternity Care,”* an implicit bias training course that provides health care professionals with important insights to recognize and remedy implicit bias in maternity care settings. This unique learning experience delivered in-person or through a self-paced, e-learning platform provides authentic and compelling content for health care providers caring for women before, during and after pregnancy. While the training alone will not lead to immediate improvements in racial and ethnic disparities, it can help professionals recognize and change behaviors that will improve patient-provider communication, quality of care and begin a culture shift towards the broader goal of achieving equity for moms and babies.

March of Dimes’ *Supportive Pregnancy Care* program is a flexible way to provide prenatal health care and education to a group of pregnant individuals. Supportive Pregnancy Care fosters health literacy and health equity and is unique in that it addresses both social determinants of health and medical factors. Supportive Pregnancy Care strives to be culturally relevant to the variety of communities served. It is also flexible, allowing organizations to personalize care to your their needs and capacity, while addressing patients' specific needs.

That's why March of Dimes endorses **H.R. 925, the *Data to Save Moms Act of 2021***, and **H.R. 943, the *Social Determinants for Moms Act of 2021***. These bills, part of the larger package of legislation under the ***Black Maternal Health Omnibus Act of 2021***, strongly supported by March of Dimes, would continue to build on bipartisan efforts to address the maternal health crisis for communities of color through data and more public investment in critical services.

H.R. 925, the Data to Save Moms Act of 2021, seeks to improve outcomes among the Native American community through greater levels of engagement in Maternal Mortality Review Committees (MMRCs) and improvements in data collection processes, quality measures for maternity care, and maternal health research at Minority-Serving Institutions (MSIs). It would commission the first-ever comprehensive study to understand the scope of the Native American maternal health crisis and establishes the first Tribal MMRC.

H.R. 925 would also invest in a review of maternal health data collection process and quality measures through engagement with key stakeholders to consider issues such as the impact of MMRC recommendations on whether or not they lead to meaningful reforms to improve outcomes or achieve equity, and the promotion of health quality measures that include safe, culturally congruent, and patient-centered maternity care.

H.R. 943, the Social Determinants for Moms Act, would focus on the negative economic and environmental impacts of the crisis with the goal of reducing the maternal morbidity rates, especially for black mothers. It would establish a federal task force to address the social determinants of health for pregnant and postpartum moms, provide safe, high-quality housing, ensure access to nutritious food for infants and extend WIC eligibility for new mothers, provide universal child care access, and study the effects of environmental risks to maternal and infant health outcomes and make recommendations for steps to end racial and ethnic disparities.

We also strongly support **H.R. 379, the *Improving Social Determinants of Health Act of 2021***, which would help empower community-based organizations, and institutions of higher education, on addressing health equity through a new grant program at the Centers for Disease Control and Prevention.

March of Dimes is proud of its data driven work to continue to build partnerships with local public and private organizations to improve maternal and infant health. The efforts from the Subcommittee today are an important step in achieving our goal of confronting social drivers of health in our most at-risk communities, and we applaud your efforts. We urge the swift advancement of these important bills and look forward to working with you toward their enactment.

ⁱ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm>

ⁱⁱ Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity | KFF

ⁱⁱⁱ Communities in Action: Pathways to Health Equity | The National Academies Press (nap.edu)



Medicare Advantage

Overcoming Barriers to Good Health

Who Medicare Advantage Serves

Nationwide more than 26 million Americans who are 65+ or living with disabilities choose Medicare Advantage for high-quality, affordable health coverage. These 26 million Americans, who are among the most vulnerable, account for over 40% of all those eligible for Medicare. More information on who Medicare Advantage serves below:

- Nearly [half](#) of all Hispanic and African American Medicare-eligibles choose Medicare Advantage.
- Medicare Advantage covers more racially diverse populations ([32%](#)) than traditional Medicare (21%), providing stable, affordable coverage for [millions](#) of low-income and minority beneficiaries.
- [57%](#) of Medicare Advantage enrollees are women.
- [40%](#) of Medicare Advantage enrollees make less than \$25,000 per year, and about 9 million have income below 200% of the federal poverty level. Many of these individuals might not be able to afford the out-of-pocket costs of traditional Medicare.
- Medicare Advantage members tend to be older than those enrolled in traditional Medicare. [63%](#) of Medicare Advantage enrollees are 70 or older, compared with 57% of traditional Medicare enrollees. Further, 24% of Medicare Advantage enrollees are between 65-69, compared with 29% of those enrolled in traditional Medicare.

Overcoming Barriers to Health

A person's health is influenced by many non-medical factors, called "social determinants of health" – where a person lives, grows, learns, and works. Medicare Advantage plans are committed to creating new programs and innovative solutions that help members overcome barriers to health, improve individual and community health, and advance health equity while giving members greater peace of mind.

Medicare Advantage plans have flexibility to offer expanded access to telehealth and supplemental benefits that go beyond traditional Medicare and can address social barriers to health. Supplemental benefits have expanded in recent years, including special supplemental benefits for the chronically ill (SSBCI). In fact, the number of Medicare Advantage plans offering SSBCI [tripled](#) in 2021 and is [growing](#).

Examples of supplemental benefits offered through Medicare Advantage that help address social barriers to health include: in-home support services, transportation to and from health care appointments, transportation for non-medical needs, and home delivery of essential supplies, including prescription drugs and groceries. Medicare Advantage plans may also offer services to eligible enrollees that address social needs, such as club memberships, family counseling, or other programs to address social isolation. Supplemental benefits can play a significant role in improving or maintaining health and overall function for chronically ill Medicare Advantage members.

Regardless of social and financial conditions, seniors and individuals with disabilities deserve to know they can count on the valuable benefits and affordable, high-quality coverage provided by Medicare Advantage. Medicare Advantage is delivering better services, better access to care, and better value to more than 26 million Americans. That's why [94%](#) of seniors on Medicare Advantage are satisfied with their health care coverage, and why a [growing number](#) of Americans choose Medicare Advantage year over year.

Spotlight on Health

Analysis of COVID-19 Impact on Medicare Advantage and Fee-for-Service Beneficiaries

05.18.21

Analysis of COVID-19 Impact on Medicare Advantage and Medicare Fee-for-Service Beneficiaries

Methodology

- Analyzed the **Medicare Current Beneficiary Survey (MCBS) COVID-19 Fall Supplement Public Use File, released in January 2021**
 - A nationally representative, cross-sectional telephone survey of Medicare beneficiaries during 2020
- Produced a comparative analysis of COVID-19 experience for Medicare beneficiaries in Medicare Advantage (MA) compared to those in Fee-for-Service (FFS)
 - Analyzed full dual eligibles and other beneficiaries (combining partial duals and non-dual eligibles)
- Focused on the differential impacts of COVID-19 such as forgone care, preventative behaviors, and impacts on daily life on seniors in Traditional Medicare FFS and Medicare Advantage enrollees

Funding for this analysis was provided by America's Health Insurance Plans

Dual Eligible Beneficiaries

Dual eligibles in Medicare Advantage are more vulnerable but experienced fewer care disruptions during COVID-19

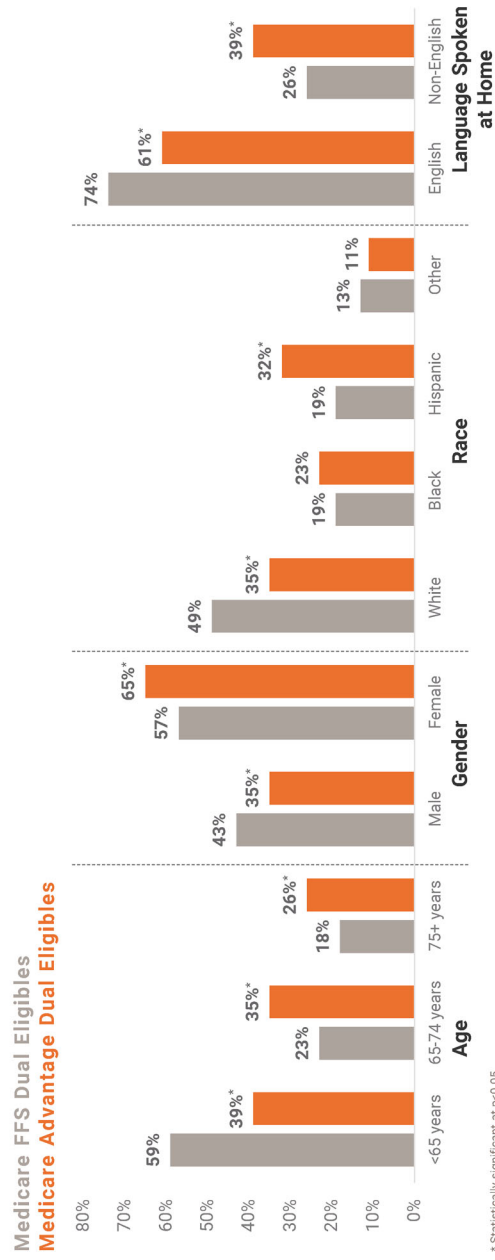
Medicare Advantage (MA) plans enroll higher risk dual eligible beneficiaries, compared to duals in fee-for-service (FFS)

- Duals in MA tend to be older and have more chronic conditions compared to FFS
- Duals in MA are also more likely to be Black or Hispanic and speak another language at home
- COVID-19 highlights unmet social needs for duals enrolled in MA

However, duals in MA experienced less foregone care than those in FFS

- Duals in MA were less likely to have difficulty accessing routine and urgent care
- Duals in MA were more likely to be offered telehealth visits during COVID-19

Compared with FFS, duals in Medicare Advantage tend to be older and more racially/ethnically diverse

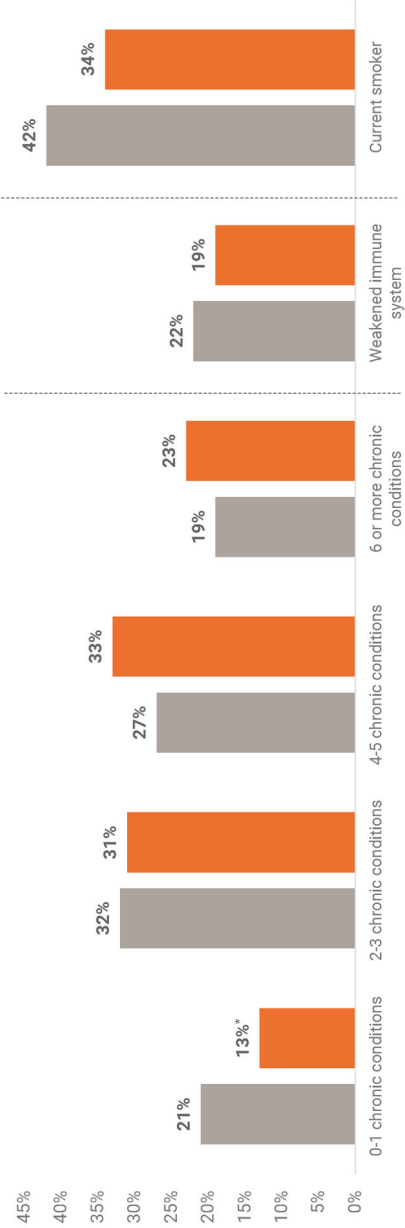


* Statistically significant at $p < 0.05$

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020.

Medicare Advantage duals report having more chronic conditions, compared to FFS duals

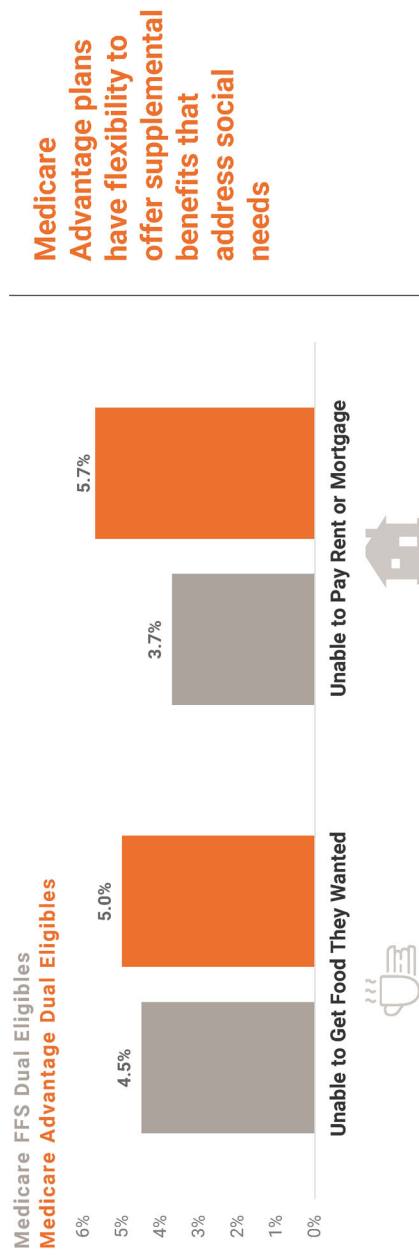
Medicare FFS Dual Eligibles
Medicare Advantage Dual Eligibles



* Statistically significant at p<0.05

Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020.

In addition to poor health, full duals have social risk factors that impact their health during COVID



* Statistically significant at p<0.05
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020.

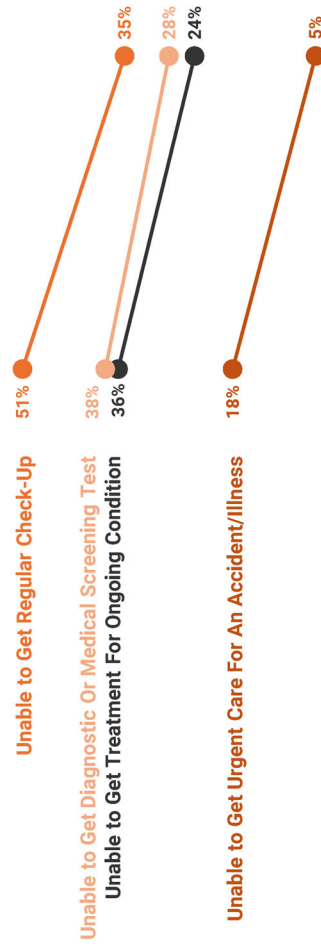
Social Isolation

Full dual Medicare FFS beneficiaries (32.8%)* reported **feeling less socially connected to family and friends** during the pandemic compared to full dual Medicare Advantage beneficiaries (23.1%)

*Statistically significant at $p < 0.05$
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020

Full-duals enrolled in Medicare Advantage reported fewer disruptions in regular care than their FFS counterparts

Among those who reported foregone care in 2020:



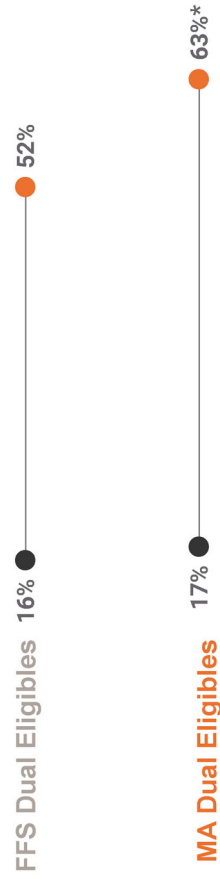
* Statistically significant at p<0.05
Responses reported for beneficiaries who reported any foregone care.
Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020.

Access to telemedicine increased exponentially during the COVID-19 pandemic

Medicare Advantage dual eligible beneficiaries were significantly more likely to report that their provider offered telemedicine visits during the pandemic, compared to FFS duals



Before the Pandemic During the Pandemic



* Statistically significant at $p < 0.05$
 Source: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Medicare Current Beneficiary Survey, COVID-19 Fall Supplement Public Use File, 2020



June 23, 2021

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the American Academy of Family Physicians (AAFP) and the 133,500 family physicians and medical students we represent, I applaud the committee for its continued focus to address health equity, including systemic racism, and improve data reporting. I write in response to the hearing: "Empowered by Data: Legislation to Advance Equity and Public Health" to share the family physician perspective.

Family physicians are woven through the fabric of our communities and see firsthand how pervasive racial inequalities are and how they continue to contribute to poor health outcomes. Numerous social, genetic, and environmental factors influence health to varying degrees, and an individual's health is not measured simply by the absence of disease. Research clearly shows and documents the greater burdens of illness, disease, and death experienced by racial and ethnic minorities in this country.¹ As such, family physicians can mitigate health inequity, including systemic racism, by collaborating with community stakeholders to affect positive change for the populations they serve.

The AAFP is working to develop strategies that promote health equity through identifying and incorporating social determinants of health in all health care delivery systems – with the goal of prioritizing preventive health and management of chronic conditions. We support [Health in All Policies](#) as a strategy to improve population health and advance health equity, and developed a toolkit for physicians through the [EveryONE Project](#).

Addressing health inequity is important not only from an equity standpoint but also for bettering health more broadly by improving overall quality of care and population health. Additionally, health disparities are costly. Analysis estimates that disparities lead to approximately \$93 billion in excess health care costs and \$42 billion in lost productivity each year as well as economic losses due to premature deaths.²

The AAFP supports, **H.R. 379, the Improving Social Determinants of Health Act of 2021**, which would create a new Social Determinants of Health (SDoH) program at the U.S. Centers for Disease Control and Prevention (CDC). The new CDC program would examine the social, economic and environmental factors that drive inequities and fund activities that address these issues. The AAFP [supports](#) policies and practices that address SDoH to help reduce health inequities.

STRONG MEDICINE FOR AMERICA

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June 23, 2021

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H.R. 666, the Anti-Racism in Public Health Act of 2021, would direct the CDC to declare racism a public health crisis, as the AAFP has [called](#) for, and would establish necessary research opportunities to understand and address the effects of racism on the health and wellbeing of communities of color in the U.S. Specifically, the CDC would establish a National Center on Antiracism and Health and a law enforcement violence prevention program. The AAFP supports the legislation, [opposes](#) systemic racism that persists in our society and many of our institutions, including in health care, and [recognizes](#) that discriminatory policing and the use of excessive force pose health and safety hazards to individuals and communities of targeted populations.

The AAFP [supports](#) the Black Maternal Health Momnibus package and applauds the committee for considering **H.R. 925, the Data to Save Moms Act** and **H.R. 943, the Social Determinants for Moms Act**. The Data to Save Moms Act increases funding to promote greater levels of diverse community engagement in maternal mortality review committees, and supports improvements in data collection processes, quality measures for maternity care, and maternal health research. The Social Determinants for Moms Act makes key investments and advances critical research on social determinants of health to improve maternal health outcomes and reduce racial and ethnic disparities. These two bills would help address our national's maternal mortality crisis, which disproportionately impacts communities of color.

The AAFP has since the beginning of the COVID-19 pandemic has [called](#) for more robust data, particularly for minorities since they have been disproportionately impacted. **H.R. 976, the Ensuring Transparent Honest Information on COVID-19 Act** requires COVID-19 data reporting, including demographic information to the CDC, by states and localities, which will be reported publicly, and funds a study to examine public health data and infrastructure during and after the COVID-19 public health emergency. The Academy supports the legislation since it aims increase transparency in COVID-19 data reporting and would provide better data to access health disparities.

The AAFP supports **H.R. 2125, the Quit Because of COVID-19 Act**, which would ensure that all Medicaid and Children's Health Insurance Program (CHIP) enrollees have access to the full array of proven tobacco cessation treatments at this critical time. This legislation is timely as COVID-19 has disproportionately impacted Black, Hispanic and Native Americans and other vulnerable populations. Additionally, a growing body of evidence demonstrates that tobacco users are at greater risk of severe complications from COVID-19.³

H.R. 2503, the Social Determinants Accelerator Act of 2021, would provide planning grants and technical assistance to help states and communities address the social determinants of health for high-need Medicaid patients and create a government-wide council to address SDoH. The AAFP supports the legislation because it gives states new tools to develop and implement strategies to improve health outcomes by addressing the SDoH that adversely impact Medicaid beneficiaries. Such strategies will result in a healthier population and more efficient spending of federal and state health care dollars.

There is a growing body of evidence suggesting that policies that specifically address social needs, including policies targeting children and families, can improve community health outcomes and have the potential to reduce health care spending.⁴ As such, the AAFP supports **H.R. 3894, the Collecting and Analyzing Resources Integral and Necessary for Guidance for Social Determinants of Health Act of 2021**, which would require the Department of Health and Human Services (HHS) to issue and disseminate guidance to states to clarify strategies to address SDoH under the Medicaid and CHIP programs.

June 23, 2021
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Again, we thank the Energy and Commerce Health Subcommittee for its work to improve health equity. We look forward to working with you to pass these important bills. If you have additional questions, please reach out to John Aguilar, Manager of Legislative Affairs at jaquilar@aafp.org.

Sincerely,



Gary L. LeRoy, MD, FAFAP
Board Chair, American Academy of Family Physicians

¹ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 2. The State of Health Disparities in the United States. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425844/>

² Turner, A. (2020, June 15). The Business Case For Racial Equity: A Strategy For Growth. Altarum. <https://altarum.org/RacialEquity2018>

³ Gorini, G. (2020, April 8). Smoking history is an important risk factor for severe COVID-19: Blog - Tobacco Control. BMJ. <https://blogs.bmj.com/bmj/2020/04/05/smoking-history-is-an-important-risk-factor-for-severe-covid-19/>

⁴ Artiga, S. and Hinton, E. Published (2019, July 9). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. KFF. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>



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ABC MISSION:

To promote the prevention and treatment of cardiovascular disease, including stroke, in Blacks and other minorities and to achieve health equity for all through the elimination of disparities.

June 23, 2021

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
House Committee on Energy &
Commerce
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Brett Guthrie
Ranking Member
Subcommittee on Health
House Committee on Energy &
Commerce
U.S. House of Representatives
Washington, D.C. 20510

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the Association of Black Cardiologists (ABC), I am pleased the Subcommittee on Health will hold a hearing on June 24, "Empowered by Data: Legislation to Advance Equity and Public Health," which will focus on a number of bills aimed at how public health data can be used to understand the impacts of economic and social conditions on health and how that knowledge can be harnessed to drive change.

Founded in 1974, the ABC is a nonprofit organization with an international membership of 1,700 health professionals, lay members of the community (Community Health Advocates), corporate members, and institutional members. The ABC is dedicated to eliminating the disparities related to cardiovascular disease for all people of color. ABC adheres to the vision that all people regardless of race, ethnicity or gender should benefit equally from reduction in the frequency, duration and impact of diseases of the heart and blood vessels.

Everyday Racism and Social Determinants of Health

The hearing represents an important acknowledgement the contributors to structural racism must be adequately addressed, otherwise it will be more difficult to address all its downstream effects.

Everyday racism, in work or in health care, results in higher rates of coronary heart disease, diabetes, stroke and end-stage renal disease. Higher levels of stress and consequent fight-or-flight hormone activation leads to high blood pressure, lack of sleep, improper diet, mental strain and medical mistrust. Those living in poorer communities also experience reduced access to care, lack of available nutritious food, unsafe built environments and a propensity to more maladaptive, addictive behaviors such as smoking, alcoholism and medical noncompliance. The result is lower life expectancy, poorer quality of life and fewer years of productive life. More research, for which data will be integral, is needed on the link between structural racism and health care outcomes so effective interventions can be developed.

Patient health is heavily influenced by social determinants of health (SODH). An example from University of North Carolina (UNC) Health System demonstrates how quickly identifying and addressing risks can significantly improve patient outcomes. As part of UNC's population health program, nursing staff would check in with patients at risk of readmission.

Due to resource constraints, the staff needed to evaluate how to best focus their efforts on their most high-risk patients. The initial model used length of stay, acuity, co-morbidities, and emergency department visits. UNC partnered with a health analytics firm to build a better model for predicting readmissions. The new “Modern Social Determinants of Health” model did not begin from preconceived theories, but instead used machine learning to ingest and evaluate UNC’s data to generate dramatically better predictions of readmission risk. The resulting model takes risk factors into account that are not always intuitive, and it segments the population in ways that are not medically or socially obvious. Despite the “black box” effect, the results were impressive. When compared to more traditional discharge planning rules, the new model correctly predicted twice as many readmissions when 20 percent of the population was targeted for follow-up.

The lack of diversity in data is a long-standing problem, and the ABC is working to address this problem with the Cardiovascular Implementation Study (CVIS), a practice-based research registry that integrates social determinants and technology innovation to address health disparities. CVIS is enrolling diverse patients with prioritized health conditions from collaborating ABC member practices, as well as patients from academic health centers and Federally Qualified Health Centers. CVIS prospectively collects socio-demographic and economic data at the point of care. CVIS will evaluate the safety and clinical outcomes of new therapeutic agents, including post-marketing surveillance. CVIS data collection tracks quality of care standards established by the Centers for Medicare and Medicaid Services and commercial health plans. Long term, CVIS will become the most comprehensive patient registry for diverse patients with cardiovascular disease and co-morbid conditions by providing real-world data to address health disparities. CVIS will inform cardiovascular algorithms and guide future research that is relevant to diverse populations.

Black Maternal Health

The ABC is a supporter of and advocate for the *Black Maternal Health Momnibus*, which addresses every dimension of the Black maternal health crisis and includes the *Data to Save Moms Act* (H.R. 925) and the *Social Determinants for Moms Act* (H.R. 943) — both of which will be discussed during the June 24th hearing.

We know many disorders manifest first in pregnancy and can impact a woman’s health later in life, including cardiovascular disease which is now the leading cause of death in pregnant women and women in the postpartum period.

Tackling the alarming rates of maternal mortality for Black women in the United States includes making critical investments in social determinants of health that influence outcomes, like housing, transportation, and nutrition. Toward this end, we encourage passage this year of H.R. 925 and H.R. 943, as well as the other bills that comprise the *Momnibus*.

Tobacco Control

Cardiovascular disease remains the leading cause of death in the United States, and while there have been improvements in life expectancy — which have attenuated in recent years — disparities in treatment and the gap in mortality between African Americans and whites persist. Among the factors that limit health care knowledge and medical advancements in cardiovascular disease treatment from reaching all communities and contribute to adverse outcomes in minorities is tobacco use.

African-Americans can improve their odds at preventing cardiovascular disease by not smoking. One critically important step that can be taken to reduce the rates of smoking among African Americans is banning the sale of menthol and other flavored tobacco and nicotine products — gateways to life-long smoking addiction and heart disease. Toward this end, we are encouraged the Food and Drug Administration recently announced it will initiate rulemaking to prohibit menthol cigarettes and flavored cigars (including menthol-flavored cigars). It is time for the predatory practices of the tobacco industry on African-Americans and young people who disproportionately use menthol-flavored products to come to an end.

We applaud the Subcommittee for including the *Quit Because of COVID-19 Act* (H.R. 2125) among the legislation that will be discussed during the June 24 hearing. The bill would provide Medicaid and Children's Health Insurance Program (CHIP) enrollees access to the full array of evidence-based tobacco cessation treatments. The ABC, alongside the Campaign for Tobacco-Free Kids and more than 50 other organizations, is proud to endorse H.R. 2125 and calls for its passage by Congress this year.

Conclusion

The ABC commends this Subcommittee for its commitment to improving health equity and eliminating disparities in care. Please know the ABC stands ready as an expert resource to you and looks forward to future opportunities for engagement. Should you require additional information, please contact Camille Bonta, ABC policy consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,



Jennifer L. Ellis, MD, MBA, FACS, FACC
Co-chair ABC Policy and Advisory Committee
Chief of Cardiothoracic Surgery Bellevue Hospital NYC H+H
Clinical Associate Professor, Department of Cardiothoracic Surgery
NYU Grossman School of Medicine



Paul L. Underwood MD, FACC, FSCAI
Co-chair, ABC Policy and Advocacy Committee
Medical Director, Interventional Cardiology/Structural Heart Boston Scientific Corporation



Statement for the Record

Submitted by Aligning for Health

"Empowered by Data: Legislation to Advance Equity and Public Health"

House Committee on Energy & Commerce, Subcommittee on Health

June 24, 2021

Aligning for Health is pleased to submit this statement for the record and appreciates that Chairwoman Eshoo and Ranking Member Guthrie are holding this hearing to examine the importance of legislation to advance equity and public health.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors.

As a coalition, we work to develop and promote actionable policies that create opportunities - and remove challenges - for states and local governments, health care organizations, and non-health care organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs.

We strongly support the Committee's efforts to assess and discuss what actionable steps Congress can take now to improve access to, and the coordination of, public health, health care and social services. Improving data sharing and the delivery and coordination of care across public health, health care, and social service sectors will help to address upstream social factors, address unmet social needs, and improve health outcomes for all.

Social Determinants Impact Health Outcomes and Drive Health Inequities

There is a significant body of academic work showing that economic and social conditions have a powerful impact on individual and population health outcomes as well as health care costs. These non-clinical factors – such as housing, food assistance, income, employment status, education and transportation – have the potential to contribute to health outcomes more than clinical health care. In fact, one widely cited study found that while ten percent of premature deaths in the U.S. are due to clinical health care, social and environmental factors are estimated to account for sixty percent of health outcomes.¹ Meanwhile, the health and economic impacts of the COVID-19 pandemic are far reaching but have had an outsized impact on many vulnerable and underserved communities.

Importance of Cross-Sector Coordination

States, local governments, health care providers, payers, social services providers, community-based organizations (CBOs), and others are increasingly seeking to partner to better coordinate care and

¹ Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.



services. Meanwhile, many states are more deeply integrating social determinants of health strategies within their Medicaid programs, with help from the Centers for Medicare and Medicaid Services.^{2,3}

However, one of the greatest challenges to high-impact interventions is the difficulty in navigating and coordinating fragmented and complex programs aimed at addressing health care needs, food insecurity, housing instability, workforce supports, and transportation reliability, among others. In particular, the siloed funding, data systems, and administration of many of these programs at the state and local, and nongovernmental levels create barriers to effective coordination and partnership.

The bipartisan **Social Determinants Accelerator Act (H.R. 2503)** will combine targeted technical assistance with grant funding to empower communities to develop Social Determinants Accelerator Plans. These Accelerator Plans will drive innovative, evidence-based interventions, coordinate resources, and identify barriers to integrated systems-level approaches to addressing both the health and social needs of families and individuals on Medicaid.

Additionally, the Social Determinants Accelerator Act would create an inter-agency technical advisory council on social determinants of health. The Council would include program experts from across the federal government, including the Department of Housing and Urban Development, the Department of Labor and the United States Department of Agriculture, as well as state and local government officials, the private sector and CBOs. This council would be well positioned to identify areas where the federal government is collecting and leveraging social determinants data, how federal funding is addressing health disparities, and coordinate the effective use of federal resources accordingly.

As the Committee discusses how Congress can advance health equity, we urge you to consider the Social Determinants Accelerator Act. This legislation is low-cost, ready to implement, and has the support of nearly 100 leading organizations.⁴

We also support the following bills being considered by the Subcommittee:

- The **Improving Social Determinants of Health Act of 2021 (H.R. 379)**, which would establish a social determinants of health program at the Centers for Disease Control and Prevention and would provide grants to public health agencies and CBOs to address social determinants of health.
- The **Social Determinants for Moms Act (H.R. 943)**, which would develop a strategy and coordinate federal efforts to understand and address social determinants of maternal health with respect to pregnant and postpartum individuals.
- The **Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants of Health Act (H.R. 3894)**, which would require the Secretary of HHS to provide guidance and technical assistance to states on how to address social determinants of health through Medicaid and CHIP.

² Kaiser Family Foundation, 2019. States Reporting Social Determinant of Health Related Policies Required in Medicaid Managed Care Contracts. Available here: <https://bit.ly/3wQXv7y>

³ CMS. 2021. Opportunities in Medicaid and CHIP to Address Social Determinants of Health. Available here: <https://bit.ly/3yOubvB>

⁴Aligning for Health, Social Determinants Accelerator Act. Available here: <https://bit.ly/35LtQRO>



Importance of Collecting, Reporting, and Exchange of Health & Social Needs Data

As noted, the siloed way in which health care, public health, and social services are paid for and administered has limited cross-sector coordination and data sharing across organizations in the health and social service sectors. Breaking down the siloes and incentivizing connectivity and coordination between programs and systems will help to ensure that they are most effective in improving health and wellbeing.

Over the past few years, CMS and HHS have made strong investments and have taken significant steps to promote and require interoperability and exchange of health data. However, social services and CBOs have not benefitted from the same level of infrastructure and systems funding, and often experience difficulty in connecting with and sharing information with health care organizations.

Statewide or regional efforts to connect health care organizations and CBOs for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination help to bridge some of these gaps. Integrated network models like North Carolina's NCCARE360 bring together CBOs, private foundations, health care organizations, and technology vendors to provide a common point of connection and resources, alleviating the burden of multiple one-off connections and exchanges. Coordinated networks also provide users with greater insight on resource availability and allocation across health and social services providers.

The bipartisan **Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act (S. 509)**^{5,6} would provide needed funding to states, through public-private partnerships, to catalyze, establish, and augment efforts to better connect and share information across sectors.

This one-time seed funding for states would facilitate cross-sector referrals, communication, service coordination and outcome tracking between social service providers and health care organizations by establishing or expanding secure, connected technology networks. States will have flexibility to design networks that are responsive to the unique cultures, infrastructure, and needs of their state. Funding can also be used to provide technical assistance and to support associated entities in connecting with and participating in the community integration network infrastructure, and to plan for and implement actions to create sustainable funding models to support the long-term success of the models.

We strongly support the Committee's efforts to assess and discuss what actionable steps Congress can take now to improve access to, and the coordination of, public health, health care and social services to advance health equity.

Thank you for the opportunity to share our comments and perspective. Please contact Chris Adamec at cadamec@aligningforhealth.org with any questions or if we can be a resource in any way.⁷

⁵ LINC to Address Social Needs Act, S. 509, available here: <https://bit.ly/3gsEO7F>

⁶ Aligning for Health, LINC to Address Social Needs Act. Available here: <https://bit.ly/35NdqI2>

⁷ Aligning for Health tracks all legislation related to social determinants of health and health equity, which are posted here: <https://bit.ly/35Qtqc9>



Expanding Access to Care and Social Supports

Addressing social determinants is the foundation to improving health outcomes. While there is increasing attention on Social Determinants of Health (SDOH), Anthem's affiliated health plans have always focused on impacting social determinants as a critical component of integrated care and healthy communities.

We understood from our beginning that if someone is experiencing challenges with an unstable housing situation or food insecurity, basic health care becomes less of a priority. We continually invest in new programs and partnerships to help support not just access to care, but also access to the life essentials that form the foundation of healthy living.

Successful Housing First Partnerships

The **Blue Triangle Safe Haven** program was introduced in 2017 in the city of Indianapolis where approximately 12,000 individuals experience homelessness at some point each year. With housing costs paid for by the City of Indianapolis, our Indiana health plan continues to invest in wrap-around services to address an important need of members — a safe place to live. Through a low barrier, housing first, trauma-informed and harm reduction approach, they provide intensive engagement and navigation services and work with members to stabilize their physical, mental health and substance use conditions and reduce crisis utilization of health care services. Members are moved into permanent housing as soon as it can be located.

In 2015 HUD awarded Tarrant County a permanent supportive housing (PSH) grant to serve high utilizers. **Tarrant County Pathways to Housing** is a collaborative partnership between The Salvation Army, JPS Health Network, Tarrant County Community Development, and Amerigroup (an Anthem company). The program focuses on providing homeless high utilizers with housing units as a part of a comprehensive care plan. The goal is to improve health outcomes and reduce the number of Emergency Department visits made by homeless individuals who were high utilizers of emergency care. The program launched in November 2015 and was created to provide rental assistance, long-term comprehensive case management, and supportive services for 14 chronically homeless individuals at scattered sites within Tarrant County. In total, the program has housed thirty-nine homeless high utilizers since 2015 and was approved for expansion in the 2018 HUD Continuum of Care (CoC) competition.

Blue Triangle Results

- 160** members served
 - All **160** members participated in housing case management
- 32%** decrease in medical spend for these members
 - **102** members were assisted with housing application completion
- 22,907** services have been provided
 - **57%** have exited positively into stable housing or treatment

- Program retention is **69%**
- **95%** of clients have remained housed in the program for one year or more
- JPS Emergency Department has saved more than **\$1M** in costs
- Total rate of admissions **decreased by half** from Year 0 to Year 3 among participants

Other Housing Partner Highlights

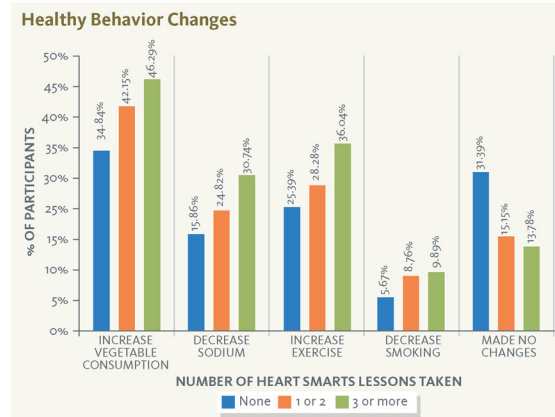
Ohio Star House	California City of Sacramento	Wisconsin Milwaukee County Housing and Redevelopment Agency
Housed 24 Transition Age Youth households including 18 children for an average cost of \$1,208. One year later all 24 households are still living in their home.	Pathways to Health + Home program has enrolled over 1,000 patients and re-housed almost 250 since inception.	Provides rent and tenancy support for high utilizers or complex care members. 71% of participants experienced decreased medical spend post-housing placement.

Impacting Communities Through Expanded Healthy Food and Nutrition Resources

Research indicates that poor nutrition, often a result of food insecurity, is a leading risk factor for many chronic conditions, including heart disease, hypertension, diabetes and other diet-related diseases. And food insecurity is reported to cost the healthcare system an additional \$53 billion a year.

The Anthem Foundation partnered with The Food Trust to expand and promote access to heart-healthy foods, including culturally relevant foods and locally grown fresh produce where possible, in neighborhood food stores. Through the Anthem Foundation grant, The Food Trust also launched its Heart Smarts program, an evidence-based approach for community-clinical linkages in neighborhood food stores. Heart Smarts includes nutrition education on a heart-healthy diet coupled with health screenings (e.g., blood pressure) to teach shoppers how to shop heart-healthy and provide a convenient, trusted location for residents to access preventive care from community health workers or health educators.

Table: Heart Smarts participants across all three cities (San Jose, Cleveland and Indianapolis) showing decreased cardiovascular risks by final month of programming, December 2019.



The Food Trust estimates that more than 39,000 individuals were positively impacted by the Healthy Food Retail enhancements made to neighborhood stores in San Jose, California, Cleveland, Ohio, and Indianapolis, Indiana.

Innovative Approaches for Reducing Rural Food Insecurity

According to Feeding America, 52% of counties with the highest rates of food insecurity are in rural areas. Across Anthem's Medicaid plans, more than 59% of our services area is rural, and we understand and work to address the unique challenges faced by these communities.

In Texas, our health plan partnered with United Family and the South Plains Food Bank to increase access to healthy foods in 20 of Texas's most rural and underserved counties, launching a refrigerated mobile pantry in September 2020. Food bank nutrition educators will travel with the vehicle to assist individuals with selecting items and building food boxes. Educators will provide printouts of quick nutrition facts and health benefits about products that are available in the trailer as well as recipe cards, food samples and meal prep advice. They will also provide nutrition education and cooking demonstrations to help clients make healthy choices.



In West Virginia our affiliated health plan is collaborating with Think Kids and the West Virginia Chapter of the American Academy of Pediatrics to build better bridges between healthcare and access to healthy food. The Health and Hunger Summit Series is a virtual series that took a candid look at connections between the health care system and community resources that address hunger in West Virginia. More than 70 participants have registered for the sessions, which concluded with an audience-engaged session to identify next steps to promote positive policy change and bridge the gaps between health and hunger.

Simplifying Access to Care



In 2018 our West Virginia affiliated health plan launched a paramedicine outreach program, aligned with their community-based care management model, through a partnership with Kanawha County Emergency Ambulance Authority. Through analytics, the health plan identified members who may benefit from care management, but who have been non-responsive to outreach. These members are often affected by multiple SDOH factors, such as environmental needs, transportation restrictions, and financial limitations. Community paramedics are able to complete in-person outreach, conducting assessments and connecting members to available community resources, health education, and immediate care needs and then linking them to health plan care managers.

Since implementation:

- **40%** of members contacted agreed to complete the assessment
- **74%** of members who completed the assessment went on to complete a care management program



Over the years, our Indiana affiliate health plan has worked closely with the Indiana Rural Health Association (IRHA) on various initiatives to expand access to school-based services. In 2016, the health plan provided grant funding to the IRHA, through a collaboration with the Indiana Primary Care Health Care Association IPHCA and the Upper Midwest Telemedicine Resource Center. Together, they supported the establishment of a telemedicine site at Landis Elementary School in Logansport. Facilitated by a presenter at the school location or the school nurse, students can connect to a clinician for immediate treatment on demand. From September 2018 through November 2019, 74 children received visits through the site.

Due to the program's success: Four additional school-based telemedicine sites are planned for rural Putnam, Monroe, and Owen counties based on the success of the initial site at Landis Elementary School.

Beyond increasing access to behavioral health counseling, the sites will also expand the availability of physical health visits through TytoCare's portable digital solutions. TytoCare's Virtual Exam Platform and suite of medical-grade, FDA-cleared handheld devices connect patients to clinicians for a complete virtual office visit.



Access to transportation can be a key driver of health. In 2019, our health plan affiliate in Tennessee partnered with Lyft to improve access to care for its members. The health plan started with a 12-month pilot in Memphis, and given early successes, quickly moved to scale the service statewide.

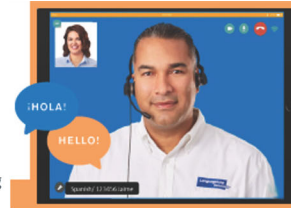
"Lyft has actually made it easier for our members to access primary care," said Rob Garnett, president of Amerigroup Tennessee. "Before, when someone wasn't feeling well and had to schedule a ride three days in advance, that delay in seeking care meant they may end up in an emergency room or urgent care as a result. We've made it easier and faster for members to meet with their doctors and ultimately stay healthy."

Results-to-date include:

- **50%** decrease in primary care gaps
- **44%** increase in primary care physician (PCP) visits
- **90%** decrease in transportation-related grievances
- **92%** of rides receive 5/5 stars

Our California affiliated health plan has deployed more than 300 hundred Digital Solutions Kiosks inside 120 safety net health centers across the state since January 2020 to provide real-time video interpretation services and access to telehealth.

This first-to-market solution is compatible with other health insurance reimbursement models. The kiosks help clinicians overcome communication barriers and improve service to the growing number of non-English speaking residents in California.



Impact of language barriers



Risk of incorrect diagnosis, duplicative testing, and inappropriate prescribing increases



Individuals may be less likely to seek care or build trusting relationships with their doctors and less likely to adhere to treatment programs

Anthem's kiosks include Wi-Fi enabled tablets that:

- Allow treating clinicians to engage certified interpreters in more than 240 languages, including American Sign Language
- Eliminate the need to pre-schedule in-person interpreter appointments or wait with third-party call centers
- Promote whole person care by providing access to medical specialists via telehealth, patient and health plan portals, patient health insurance information, and available community resources

This transformative, multi-payer solution has already reduced costs and administrative burdens for many health centers, realizing \$44k in savings, with hundreds of thousands of dollars in savings expected as the initiative grows.

Anthem is a leading health benefits company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves more than 106 million people, including more than 42 million within its family of health plans. We aim to be the most innovative, valuable and inclusive partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.

Not for sales or marketing purposes

SDOH_1020

Social Determinants of Health

Energy and Commerce Committee Staff

June 16, 2021

Office of Policy and Representation



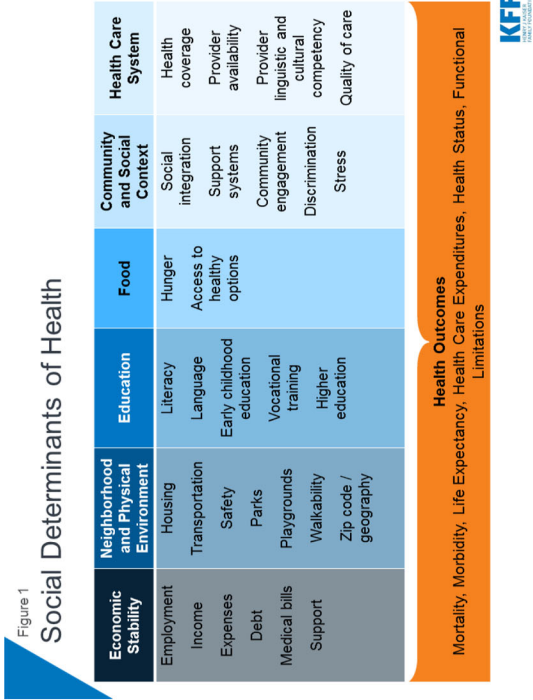
Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

Agenda

- What are Social Determinants of Health (SDOH)?
- How do insurers work with SDOH?
- BCBS SDOH Plan Examples
- Recommendations

What are Social Determinants of Health?

What are Social Determinants of Health?



Social Determinants

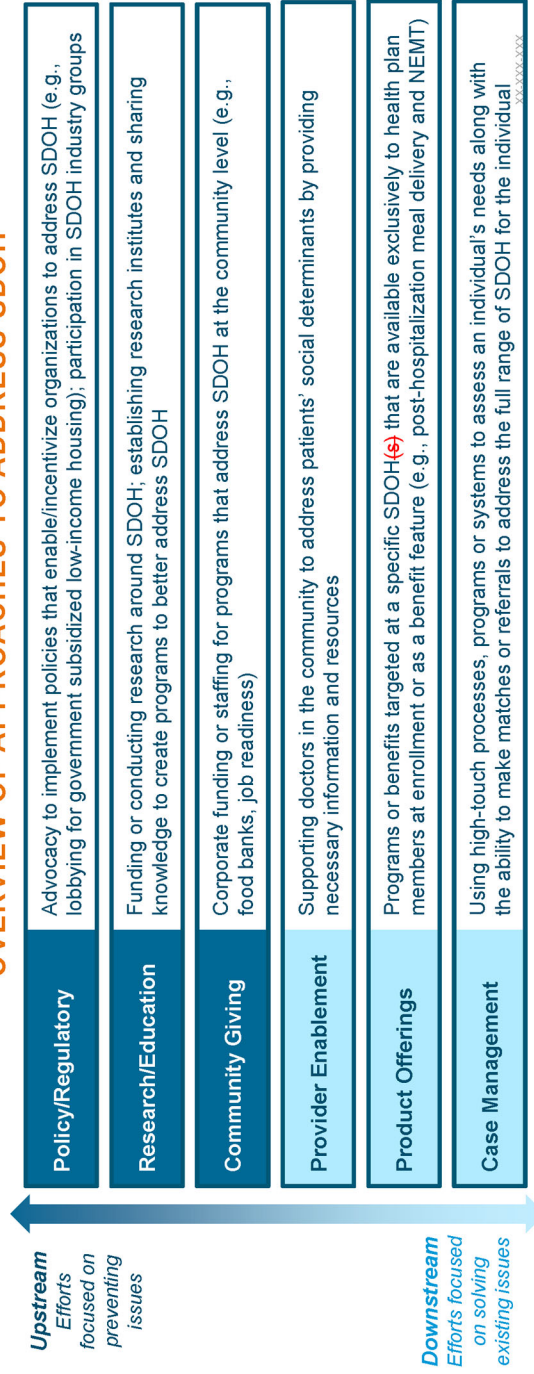
- Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- Conditions (e.g., social, economic and physical) in these various environments and settings (e.g., school, church, workplace and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes.
- Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.*

* <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

How do insurers work with SDOH?

Health insurers utilize several approaches to address social determinants

OVERVIEW OF APPROACHES TO ADDRESS SDOH



BCBS SDOH Plan Examples

(Examples are a sample of BCBS projects)

Housing Supports

Rhode Island

- In a targeted effort to address some of the most basic health inequities for Rhode Islanders, [Blue Cross & Blue Shield of Rhode Island \(BCBSRI\)](#) has – for the second year now - directed the focus of its BlueAngel Community Health Grant program (BACHG) toward improving access to safe and affordable housing.
- Building on an initial grant of \$500,000 in 2020, BCBSRI has now awarded an additional \$500,000 in a second round of funding to nine local organizations aimed at closing the gap for Rhode Islanders whose health outcomes are directly tied to housing quality.

Maternal Supports

Arizona

- [Blue Cross Blue Shield of Arizona \(BCBSAZ\)](#) is the state's largest health insurer. Partnering with Arizona's tribal nations, the company is committed to supporting native mothers and newborns through culturally appropriate interventions.
- The health insurer's public health initiative, [Mobilize AZ](#), focuses on key health issues impacting Arizonans - substance use disorder, mental health and diabetes, as well as social determinants of health. The initiative earmarks millions of dollars each year to build statewide capacity and resources for substance use disorder prevention, treatment, resiliency and recovery efforts. Funding priority is given to projects that expand resources, increase systems-level capacity, target an identified vulnerable population, and have a measurable impact.

Maternal Supports

Illinois

- [Blue Cross Blue Shield of Illinois \(BCBSIL\)](#) is supporting parents in Chicago's South and West Side neighborhoods by providing funding to community-based organizations working to improve maternal health outcomes. The organizations utilize doulas, midwives and telemedicine to provide education, labor care, breastfeeding help and postpartum support within a culturally appropriate lens.
- BCBSIL is also teaming up with Centering Healthcare Institute, a non-profit focused on delivering better health outcomes and improving the care experience for patients and their doctors. Through a three-year grant, BCBSIL will be bringing CHI's Centering Pregnancy program to several Federally Qualified Health Centers (FQHCs) that focus on serving underserved and at-risk populations.



Food Insecurity Supports Minnesota

- [Blue Cross and Blue Shield of Minnesota \(BCBSMN\)](#) is offering mothers and families in need clinically tailored meals and food boxes as well as nutritional coaching.
- Members can start as early as 20 weeks into their pregnancy and continue through the second month after birth. The program is a partnership with Project Well and Second Harvest Heartland, which will deliver the food and the coaching.
- Members also have access to [doula services](#) that are supportive, culturally sensitive prenatal care can that makes the difference for pregnant women at risk of birth complications. A doula is a woman trained to support pregnant women emotionally and physically during pregnancy, childbirth and postpartum. There's evidence to suggest that working with a doula can reduce negative health outcomes among women of color. BCBSMN is addressing the sustainability of the doula model, including increases in reimbursement, culturally appropriate access, workforce development scholarships and member education.

Food Insecurity Supports

Missouri

- [Blue Cross and Blue Shield of Kansas City \(Blue KC\)](#) works with local food banks and food distributions centers to help members who are pregnant or new moms. Mothers who continue to experience food insecurity are connected with a state food assistance program.
- The health plan trains front-line providers to screen women for food insecurity. Then Blue Cross and Blue Shield of Kansas City community health workers connect those members to resources to meet their social needs and follow up with providers.
- *Well Stocked*, a new Blue KC initiative, is focused on bringing local partners together to increase awareness of hunger issues facing underserved areas in Kansas City.

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Recommendations

MEDICAL LOSS RATIO (MLR)

- **What is an MLR?**

- A Medical Loss Ratio (MLR) is applied to all capitated Medicaid managed care plans.
- This oversight tool sets a threshold for the minimum proportion of expenditures that health plans should dedicate to enrollee services, as opposed to administrative costs.
- This acts as a stop-gap to ensure Managed Care Organizations are utilizing taxpayer dollars appropriately.

- **Why This Matters?**

- Poorly conceived MLRs can discourage plans from covering nonclinical services.
- Several states counted care management as administrative services when implementing a Medicaid MLR, which meant that health plan investments in care management negatively impacted the plans' MLRs.

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Recommendations

- **Legislative**
 - Congress gives Centers for Medicare & Medicaid (CMS) the authority to pick and choose what SDOH services can be paid for as a medical social service.
 - This expenditure would count towards an MCO's MLR and provide plans more flexibility in investing and creating new SDOH services.
- **Regulatory**
 - Encourage CMS to explicitly state what SDOH services can be covered
 - Examples: Food insecurity, housing supports, additional transportation (outside of NEMT)

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IMPROVING BLACK MATERNAL CARE AND HEALTH THROUGH PREGNANCY AND CHILDBIRTH

Despite tremendous health advances, the United States continues to have the highest maternal death rate of any developed country. While most of the world has drastically reduced rates of maternal mortality over the past several decades, the U.S. is one of a handful of countries where the problem has not only worsened, but has worsened significantly.

Across the country, maternity care deserts, continued disparities in the rates of health insurance coverage and affordability concerns are threatening women's access to necessary care before, during and after childbirth. These barriers, among other challenges, help contribute to substantial racial disparities facing African American women.

60% OF PREGNANCY-RELATED DEATHS are preventable.¹

Black women are **3X MORE LIKELY** than white women to die from pregnancy-related complications.²

Preeclampsia and eclampsia are **60% MORE COMMON** among African American women.³

As an important step in improving Black maternal healthcare, the Blue Cross Blue Shield Association (BCBSA) strongly supports the "Momnibus" bill authored by Black Maternal Health Caucus Co-Chairs, Reps. Underwood and Adams. BCBSA is working to build support for this important legislation, which focuses on addressing gaps in the existing maternal health system that contribute to these disparities and result in Black women experiencing higher rates of pregnancy-related complications and more maternal health complications.

¹ CDC. 2019. "Pregnancy-Related Deaths | VitalSigns." Centers for Disease Control and Prevention. May 14, 2019. <https://www.cdc.gov/vitalsigns/maternal-deaths/>

² Pregnancy Mortality Surveillance System." 2019. 2019. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>

³ Finger, Kathryn, Iris Mabry-Hernandez, Quyen Ngo-Metzger, Tracy Wolff, Claudia Steiner, and Anne Elkhäuser. 2017. "STATISTICAL BRIEF #222 Highlights Delivery Hospitalizations Involving Preeclampsia and Eclampsia, 2005-2014." <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb222-Preeclampsia-Eclampsia-Delivery-Trends.pdf>

At the community level, Blue Cross and Blue Shield companies are working with physician, hospital and community partners to lead initiatives that break down barriers, address disparities and close critical access gaps for a safer and healthier pregnancy, delivery and postpartum.

HERE ARE SOME EXAMPLES:



In Maryland, Virginia and Washington, D.C., **CareFirst BlueCross BlueShield** is awarding \$2 million over the next two years to programs seeking to improve birth outcomes, maternal health and lower infant mortality rates. CareFirst already has contributed more than \$18 million to address these issues since 2007, and the investments are paying off. From 2009 to 2018, through the B'More for Health Babies Initiative, Baltimore City, whose residents often have significant unmet maternal and child health needs, saw a 36 percent decrease in infant mortality, a 38 percent decrease in the Black-white disparity in infant mortality and a 55 percent decrease in teen births.



Blue Cross & Blue Shield of Mississippi (BCBSMS) supports hospitals in improving health outcomes through the BCBSMS Maternity Quality Model. There are three focuses: the 39 Weeks Initiative, a partnership with network clinicians to reduce the number of medically unnecessary early term deliveries; Baby Friendly, which enhances the mother/baby experience through training and education; and Maternal Safety Bundles, a partnership with Mississippi Perinatal Quality Collaborative focusing on education and training for improving maternal care.

As part of Maternal Safety Bundles, BCBSMS is training healthcare professionals in hospitals throughout the state to better identify and respond to complications – including severe bleeding and high blood pressure – which are two of the most preventable causes of pregnancy-related deaths that are often undetected, misdiagnosed or ignored. They are also working towards safely reducing the number of medically unnecessary C-sections.

Finally, the Blue Primary Care Women's Wellness Home initiative is expanding the relationship between patient and OB-GYN by addressing a mother's unresolved chronic illnesses – high blood pressure, diabetes and obesity – a common source of maternal and infant complications at birth. This is helping to close a critical access gap in rural Mississippi, where the maternal mortality rate is highest.



BlueCross BlueShield of Tennessee has helped establish an extensive network of telemedicine sites in rural communities – called the Solutions to Obstetrics in Rural Communities (STORC) – to improve access to specialty care for women with high-risk pregnancies. Rather than traveling to one of the state's major cities for care, STORC sites are staffed with an ultrasound technician and an advanced practice nurse who can video conference with a specialist. Currently, there are STORC sites in 13 rural Tennessee communities, many with no obstetrical specialists or women's healthcare professionals at all. The program, which began in 2009 with 134 visits, grew to 3,953 visits in 2018. More than 90 percent of women in the program have delivered healthy babies.



Blue Cross and Blue Shield of Louisiana offers Healthy Blue Beginnings for mothers with high-risk pregnancies. The program identifies at-risk women and offers expectant mothers confidential nursing support specific to their individual needs. Expectant mothers are also encouraged to sign up for text4baby, which sends free health and safety tips via text message. Each message is tailored to the mother's due date.

Additionally, Healthy Blue, a Louisiana Medicaid health plan, takes a proactive approach to maternal and infant health offering expectant mothers the comprehensive program, New Baby, New Life. Pregnant women undergo risk assessments to determine the level of support they'll need throughout pregnancy. The program provides the women with enhanced case management, care coordination and education.

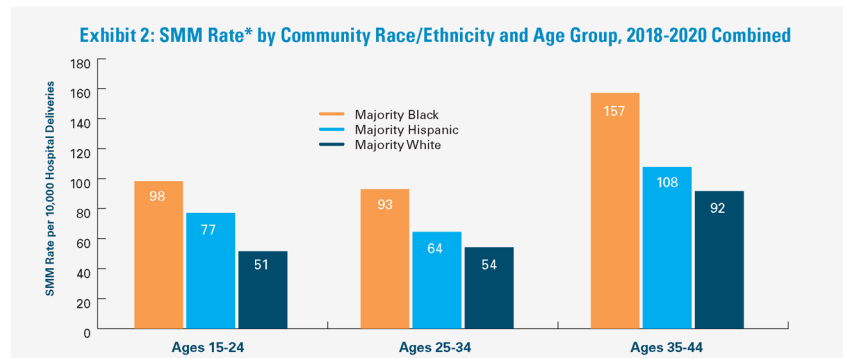
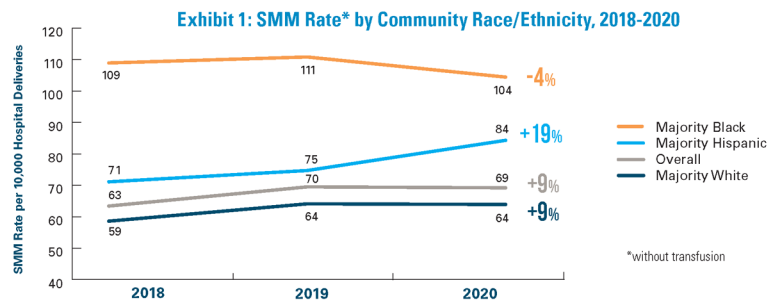


Blue Cross and Blue Shield of South Carolina is part of a statewide collaboration helping babies reach their first birthday. The South Carolina Birth Outcomes Initiative educates women about the benefits of regular prenatal care and the importance of waiting until 39 weeks before giving birth. Now, fewer babies are born with low birth weights; fewer spend their first weeks in the NICU; there has been a 30 percent decrease in babies born before 37 weeks; and infant mortality has dropped to its lowest rate in 20 years.

As part of the commitment by Blue Cross and Blue Shield companies to reduce racial disparities in maternal health by 50% in five years, BCBSA's Health of America (HoA) initiative¹ harnessed data to examine the rate of childbirth complications as measured by the CDC's Severe Maternal Morbidity Measure (SMM)—21 different adverse events or unexpected outcomes from labor and delivery with significant short- or long-term consequences to a woman's health, and in some cases, may lead to death. Our analysis included hospital births covered by Blue Cross and Blue Shield commercial insurance from January 2018 to October 2020.

Here are some findings from the HoA analysis:

While the rates of SMM have been increasing across the board, women in majority Black communities have a 63% higher rate of SMM than women in majority white communities. Women in majority Hispanic communities have a 32% higher rate of SMM than women in majority white communities. These rates are higher across all age groups and nearly all indicators. Further, Black and Hispanic women have a substantially higher prevalence than white women of the most common risk factors that put women at risk of SMM.



¹ This is the 35th study of the Blue Cross Blue Shield, The Health of America Report® series, a collaboration between Blue Cross Blue Shield Association and Blue Health Intelligence (BHI), which uses a market-leading claims database to uncover key trends and insights in healthcare affordability and access to care. Severe Maternal Morbidity (SMM) was estimated using the Centers for Disease Control and Prevention's 21 defined indicators. The indicators were identified using claims from 2.2 million hospital deliveries occurring from January 1, 2018 to October 31st, 2020. Blood transfusion was excluded from the report since many blood transfusions are not truly indicative of SMM, but often less severe in nature. The rate of SMM includes the rate of SMM indicators present per 10,000 delivery hospitalizations. A woman can experience more than one SMM during a delivery hospitalization.

Risk factors for SMM were identified using the California Maternal Quality Care Collaborative's (CMQCC) risk adjustment system. These risk factors were identified as present on admission through BCBS claims data. Risk ratio is an estimate of the SMM rate for women with the risk factor present on admission divided by the SMM rate for women without the risk factor present on admission.

Race/ethnicity is determined by ZIP code when more than 50% of the households identify as either Black, Hispanic or white. This ZIP code data is from the 2017 American Community Survey (ACS). The estimated number of pregnancies occurring in each community category are: white 612,000; Black 30,000; and Hispanic 46,000.

Exhibit 3: Prevalence Rate (per 10,000) and Differentials between Majority Black, Majority Hispanic and Majority White Communities for the Most Common SMM Indicators, 2020*

Condition	Black Mothers	Hispanic Mothers	White Mothers	Difference Black vs. White	Difference Hispanic vs. White
Acute Renal Failure	31.0	14.5	13.7	+126%	+6%
Adult Respiratory Distress Syndrome	16.3	14.5	6.8	+138%	+112%
Sepsis	15.1	11.8	5.9	+157%	+101%
Pulmonary Edema/ Acute Heart Failure	12.2	5.4	4.2	+193%	+29%
Hysterectomy	10.6	15.8	9.7	+9%	+63%
Ventilation	9.8	8.0	4.0	+145%	+102%
Shock	9.0	8.6	6.4	+41%	+35%
Eclampsia	8.6	8.0	5.5	+56%	+47%
Puerperal Cerebrovascular Disorders	5.3	3.5	3.1	+70%	+13%

*Only indicators showing a disparity across communities are shown.

The type and quality of care a woman receives while pregnant, during childbirth and after giving birth can impact a woman's likelihood of experiencing SMM. BCBSA surveyed approximately 750 women between the ages of 18 and 40 about their pregnancy and childbirth care experience in the last year, representing commercial, Medicaid, Medicare and uninsured individuals. The survey results show that, compared to white women, Black and Hispanic women say they may not be receiving the kind of care they need.

KEY TAKEAWAYS FROM THE SURVEY:

Compared with white mothers, mothers of color say they were not always able to complete the recommended series of prenatal visits, mainly because of a lack of transportation or scheduling conflicts. COVID-19 has also played a role in reducing prenatal visits.

Mothers who completed all recommended prenatal visits:



Compared to white and Hispanic mothers, Black mothers report feeling their provider did not spend enough time with them and have lower confidence they will receive the care they need. They also feel like they cannot openly speak to their provider about their pregnancy.

Mothers who felt their provider spent enough time with them:



Mothers who are confident they received/ will receive the care they needed:



Mothers who feel they can speak openly about pregnancy with their provider:



For the full HoA report on racial disparities in maternal health visit: <https://www.bcbs.com/the-health-of-america/reports/racial-disparities-in-maternal-health>.

The Blue Cross Blue Shield Association is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans. To learn more about how BCBSA is advocating to improve healthcare for all Americans, please visit www.bcbsprogresshealth.com

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MILLIMAN REPORT

Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare

October 2020

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This report was commissioned by the Better Medicare Alliance





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Executive Summary

In 2019 there were 64 million Medicare beneficiaries. Twenty-four million of those beneficiaries chose to enroll in a Medicare Advantage plan; the remainder were covered by fee-for-service Medicare. Over 37% of the total Medicare beneficiary population chose Medicare Advantage. The Congressional Budget Office (CBO) projects that Medicare Advantage enrollment will grow to nearly 50% by 2029.¹ To better understand the increasing role of Medicare Advantage for Medicare beneficiaries we looked at similarities and differences among enrollees in those two programs across several years. We conclude that overall the two programs both attract a broad mix of beneficiaries but there are some interesting differences.

The age composition of Medicare Advantage and fee-for-service Medicare are largely similar but there are a few differences worth noting. A higher share of the fee-for-service Medicare population, 29%, is between the ages of 65 and 69 compared to 24% for Medicare Advantage. The opposite is true between 70 and 84. This age group represents 52% of Medicare Advantage enrollees versus 46% of fee-for-service Medicare beneficiaries.

The share of the Medicare population enrolled in Medicare Advantage, excluding EGWPs, grew from 24% in 2013 to 33% in 2019. This represents a 63% increase in Medicare Advantage enrollment over that time period. Our examination of the journey of the 2013 Medicare beneficiaries through 2019 reflects this movement.

- Medicare Advantage enrollees are more likely to stay in Medicare Advantage. 85% of 2013 Medicare Advantage enrollment remained in Medicare Advantage through 2019, compared to 81% of fee-for-service Medicare beneficiaries.
- In addition, 15% of the 2013 fee-for-service Medicare beneficiaries moved into Medicare Advantage between 2013 and 2019, compared to the 6% that left Medicare Advantage for fee-for-service Medicare.

Racial minorities make up a larger share of the Medicare Advantage population than in fee-for-service Medicare (32% vs 21% in 2019). They also comprise a larger share of the 2013 beneficiaries that transitioned into Medicare Advantage (38% vs 35%) between 2013 and 2019.

The number of dual eligible beneficiaries, i.e., those enrolled in both Medicare and Medicaid, choosing Medicare Advantage increased significantly between 2013 and 2019.

- In 2013 there were 9.6 million full or partial dual beneficiaries, with 2.4 million (25%) enrolled in Medicare Advantage.
- By 2019 the number had increased to 12.3 million, with 5.4 million, or 44%, enrolled in Medicare Advantage.

This report was commissioned by the Better Medicare Alliance, Inc.

¹ CBO (May 2, 2019). Medicare—CBO's May 2019 Baseline. Retrieved October 2, 2020, from https://www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf

Bruce Pyenson, Catherine Murphy-Barron, Christine Ferro, and Matt Emery are employed by Milliman, Inc. The American Academy of Actuaries requires its members to identify their credentials in their work product. Pyenson, Murphy-Barron, and Emery are members of the American Academy of Actuaries and meet its relevant qualifications.

Introduction

Medicare beneficiaries have the opportunity to enroll in Medicare Advantage (MA) every year during annual open enrollment. The number of beneficiaries choosing MA each year has been steadily increasing. 2019 MA enrollment was 60% more than in 2013, but fee-for-service Medicare (FFS) increased by only 5%. In this report we explore how this growth happened by examining the characteristics of the people who chose MA and by comparing those characteristics to people who chose FFS.

Most people become eligible for Medicare when they turn 65, but some individuals qualify at younger ages through disability or because they have end-stage renal disease (ESRD). The FFS program has operated since the 1960s and covers hospitalization, outpatient services, and physician care, as well as other benefits such as home healthcare.

MA, which has operated in some form since the 1980s, allows Medicare beneficiaries to receive Medicare-covered services through private health plans. The plans almost always operate with a network of providers. MA has become increasingly popular for Medicare beneficiaries, because MA plans offer richer benefits, including reduced cost sharing or additional benefits that are not part of FFS.

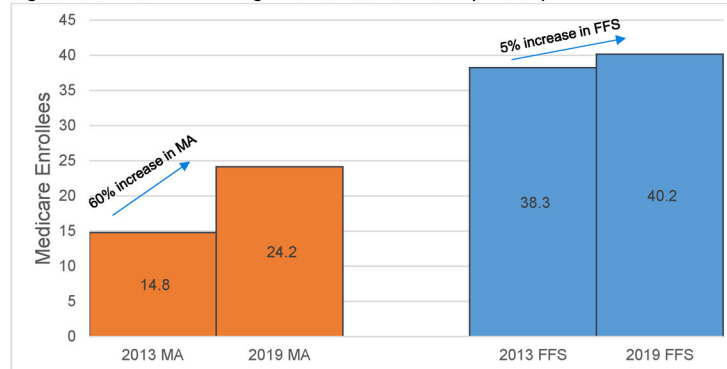
Most Medicare beneficiaries can choose between FFS and MA during an annual open enrollment period. Medicare beneficiaries may also be eligible for Medicaid based on their state's income requirements (known as "dual eligibles") and can enroll or disenroll in MA throughout the year. About 20% of Medicare beneficiaries are dual eligibles. We provide information on the two main categories of dual eligibles—the "full duals" and "partial duals." Full dual eligible beneficiaries receive full subsidies for out of pocket costs incurred on medical services as well as subsidy for Part B premiums. Partial dual eligible beneficiaries qualify for a partial subsidy of either Part B premium or their out of pocket costs.

Using the Centers for Medicare and Medicaid Services (CMS) 100% Medicare Research Identifiable Database, we examined the demographic characteristics of Medicare beneficiaries enrolled in Parts A, B, and D in 2013 and 2019. We also followed MA and FFS beneficiaries in 2013 and noted how they transitioned between MA and FFS each year through 2019. For this longitudinal analysis we included individuals with at least one valid month of enrollment in 2013 and followed them through 2019. Therefore, individuals who became eligible for Medicare after 2013 either by aging or through disability are not included in the longitudinal analysis. Beneficiaries enrolled in Employer Group Waiver Plans (EGWPs), which is a program for employers to subsidize retiree medical benefits, were included in the comparison of the total Medicare populations in 2013 and 2019 (figure 1), but excluded from the remainder of our analysis (figures 2-9). EGWPs are a function of employment and are therefore not available to all Medicare beneficiaries.

Comparing the demographics of enrollees in Medicare Advantage and Fee-For-Service Medicare

From 2013 to 2019, the number of Medicare beneficiaries enrolled in MA plans increased faster than overall Medicare enrollment. In 2013 there were approximately 53 million Medicare beneficiaries, with 38.3 million in FFS, 12.1 million in MA, and 2.7 million in EGWPs. In 2019, Medicare covered over 64.4 million individuals, with 40.2 million in FFS, 24.2 million in MA plans, of which almost 4.5 million were enrolled in EGWPs. The FFS population grew by 5% in that time period, while the MA population grew by 60%.

Figure 1: 2013 and 2019 Change in Medicare Enrollment (millions)

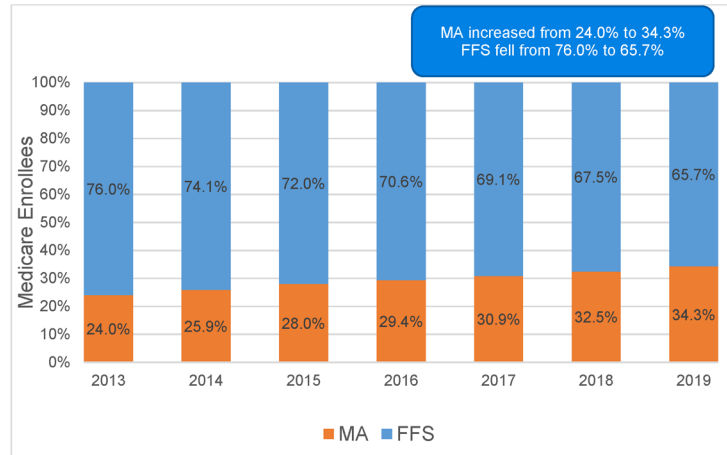


Note: MA values in Figure 1 include beneficiaries enrolled in EGWPs. However, we exclude EGWPs from the remainder of this report as EGWP is a function of employment and not available to all Medicare beneficiaries.

If we exclude EGWPs from the MA population, then MA grew by 63% between 2013 and 2019.

We exclude EGWPs from the remainder of our analysis as EGWP are offered on a group basis by some employers to their retirees and are not available to all Medicare beneficiaries. We included only beneficiaries who could choose between FFS and individually sold MA plans.

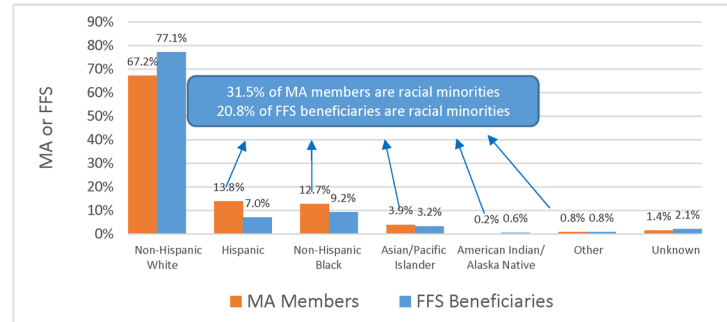
We followed the group of 50.3 million 2013 Medicare beneficiaries through 2019 to gain insight into how people moved between FFS and MA. By 2019 the surviving population of our 2013 group had approximately 36.9 million beneficiaries—a 25% reduction due to death (or loss to follow-up). However, in this “fixed block,” MA enrollment grew while the number in FFS dropped. Figure 2 shows the change in distribution for the 2013 group.

Figure 2: 2013 Medicare Cohort, MA's Enrollment Share Grows Each Year

The MA share increased from 24.0% to 34.3% between 2013 and 2019 for the surviving members of the 2013 cohort. The total overall (non-EGWP) MA penetration increased from 24.0% to 32.9% in 2019. This growth reflects the net movement of individuals from FFS to MA and not necessarily reduced mortality in MA.

RACE AND ETHNICITY

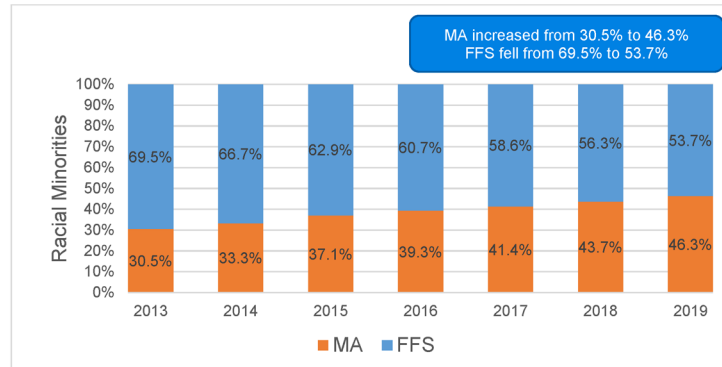
Racial minorities make up over 30% of MA enrollees compared to approximately 20% of FFS enrollees. As shown in Figure 3, the 2019 Medicare population included 16.0 million racial/ethnic minorities, with 7.6 million in MA (31.5% of MA) and 8.4 million in FFS (20.8% of FFS). MA had nearly twice the proportion of Hispanics as FFS (13.8% vs. 7.0%). MA also had more non-Hispanic Black people than FFS (12.7% vs. 9.2%).

Figure 3: 2019 MA has Higher Enrollment of Racial/Ethnic Minorities than FFS

Note: The racial/ethnic minorities reported here reflect the coding in the CMS database. We caution the reader that researchers have reported shortcomings in the racial/ethnic identification in our source data.²

In 2013 MA had 3.6 million racial/ethnic minorities, representing about 30% of MA enrollment; FFS had 8.2 million, representing about 21% of FFS beneficiaries.

² Jarrin, O.F. et al. Validity of race and ethnicity codes in Medicare administrative data compared with gold-standard self-reported race collected during routine home health care visits. *Medical Care*. 2020 January; 58(1): e1-e8.

Figure 4: 2013 Medicare Cohort, MA has a Growing Share of Racial/Ethnic Minorities

By 2019 racial/ethnic minorities made up 24.5% of the total overall surviving 2013 cohort. The proportion of racial minorities that joined MA during that period was about 62% of the MA racial minority enrollment, but the proportion joining FFS was only 10% of the FFS racial minority population.

Figure 5: 2013 Medicare Cohort Cumulative Transitions through 2019, Racial/ethnic Minorities (millions)

Transition Type	MA		FFS	
	Beneficiaries	% of 2013 Racial Minorities in MA	Beneficiaries	% of 2013 Racial Minorities in FFS
Any-Time Joiner	2.2	62%	0.8	10%
Any-Time Leaver	0.8	23%	2.2	27%
Full-Time Stayer	3.0	85%	5.8	71%

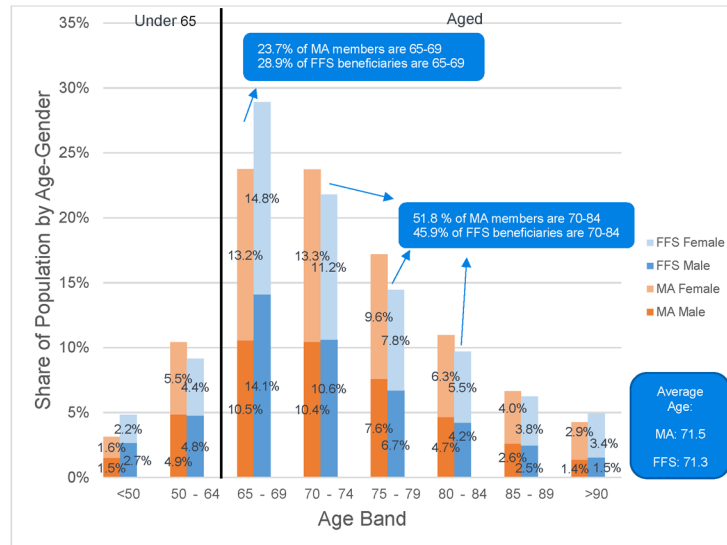
During the seven-year time period, 85% of the MA racial/ethnic minority population remained in MA for the entire period. This is consistent with the percentage of the overall population that remained in MA. FFS had a lower retention for racial/ethnic minorities (71%) versus the overall FFS retention of 81%.

AGE AND SEX

Figure 6 shows, for each five-year age band, the share of 2019 beneficiaries in MA and FFS.

- A higher share of FFS beneficiaries is between 65 and 69 than MA (28.9% versus 23.7%).
- A higher share of MA beneficiaries is between 70 and 84 than FFS (51.8% versus 45.9%).
- MA has a larger share of 50 to 64 year olds than FFS (10.4% compared to 9.2%), but a lower share of the under 50s (3.1% vs 4.8%).

Figure 6: 2019 Medicare Enrollment, Age and Sex



Note: For each cohort (MA/FFS) the sum across all age brackets equals 100%.

GEOGRAPHIC LOCATION

As a share of each population there are more MA enrollees living in urban areas than FFS. In 2019 83% of MA enrollees lived in urban areas compared to 74% for FFS. This is a slight increase from 2013 in the share of those living in urban areas for both MA (81%) and FFS (72%).

MEDICARE TRANSITIONS

Of the 53 million beneficiaries in the 2013 Medicare cohort, beneficiaries switched between MA and FFS over 8 million times by 2019, including people who switched multiple times. However, 41 million maintained their original coverage for the entire period; approximately 81% of FFS beneficiaries and 85% of MA enrollees.

Six million FFS beneficiaries joined MA, which represents 49% of the MA 2013 enrollment. Meanwhile 2.4 million joined FFS from MA, representing 6% of the 2013 FFS population. Enrollees leaving MA or FFS each represent 20% and 15%, respectively, of their 2013 populations.

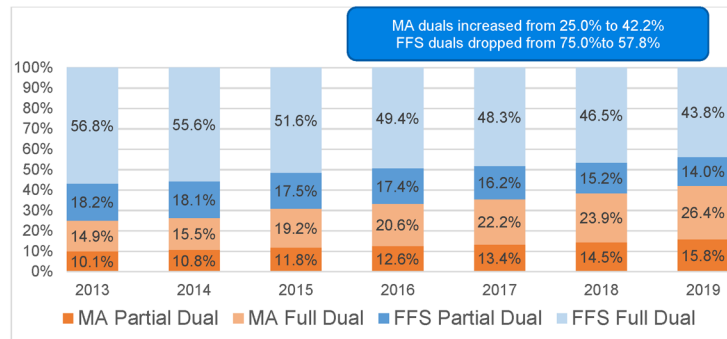
Figure 7: 2013 Medicare Cohort Cumulative Transitions through 2019 (millions)

Transition Type	MA		FFS	
	Beneficiaries	% of 2013 enrollment	Beneficiaries	% of 2013 enrollment
Any-Time Joiner	5.9	49%	2.4	6%
Any-Time Leaver	2.4	20%	5.9	15%
Full-Time Stayer	10.3	85%	30.8	81%

FULL AND PARTIAL DUALS

MA has attracted an increasing portion of dual eligibles over the period from 2013 to 2019. In 2013 there were 9.6 million full or partial duals, with 2.4 million (25%) enrolled in MA and 7.2 million (75%) in FFS. In 2019 the number of full or partial duals in Medicare increased to 12.3 million, with 5.4 million enrolled in MA (44%), and 6.8 million (56%) in FFS. This represents an overall increase in dual eligibles from 2013 to 2019 of 28%, but MA grew by 125% while FFS dropped by 5.6%. The large increase in MA enrollment for dual eligibles may have been driven, at least in part, by implementation of the Medicare-Medicaid demonstration plans in some states.

In the 2013 Medicare cohort, only 7.5 million of the starting 9.6 million dual eligibles remained by 2019. However, the number enrolled in MA had increased by nearly 0.8 million. The number in FFS fell to 4.3 million. The 2019 percentage split of duals between MA and FFS is 42% and 58%, respectively. This is consistent with the distribution for the overall 2019 Medicare population.

Figure 8: 2013 Medicare Cohort, Full and Partial Duals

In the 2013 group, duals transitioned from FFS to MA approximately 2.3 million times through 2019. However, duals left MA for FFS only 1 million times. A higher percentage of dual MA enrollees remained in MA for the entire period compared to FFS beneficiaries, 78% of MA versus 73% of FFS.

Figure 9: 2013 Medicare Cohort Cumulative Transitions through 2019, Dual Eligibles (millions)

Transition Type	MA		FFS	
	Beneficiaries	% of 2013 MA Duals	Beneficiaries	% of 2013 FFS Duals
Any-Time Joiner	2.3	97%	1.0	13%
Any-Time Leaver	0.9	39%	2.3	33%
Full-Time Stayer	1.9	78%	5.3	73%

Data Source and Methodology

DATA SOURCE

The methodology described below was applied to the 2013 through 2019 CMS 100% Medicare Research Identifiable Data Set.

METHODOLOGY

MA and FFS identification

MA members were identified as those entitled to both Parts A and B and belonging to an MA plan by virtue of reporting a health maintenance organization (HMO) buy-in value. Those identified as MA members with plan IDs in the “800” series were further identified as EGWP members and excluded from the demographic comparisons. Part D-only EGWPs were also excluded. FFS beneficiaries were identified as any remaining entitled beneficiary with Part A-only, Part B-only, or both Parts A and B.

We initially identified FFS and MA enrollees based on their March 2013 enrollment. March was chosen as it is after the annual enrollment period allowing Medicare enrollees to switch between FFS and MA coverage on or before February 14. If there was no enrollment value in March, we identified individuals as MA or FFS based on their December enrollment, similar to above. If there was no enrollment value in December we considered the individual lost to follow-up and no enrollment type was assigned. Approximately 10,000 were not assigned to MA or FFS, thus 2013 reported figures exclude that group.

From 2014 through 2018 we identified transitions by comparing the March enrollment in each year to the previous year. If there was no enrollment value in March, we considered the individual as lost to follow-up. In 2019 we identified transitions by comparing the April enrollment to the March 2018 enrollment. April was chosen to align with the Medicare Advantage open enrollment period established in 2019, which allows MA members to switch plans or return to FFS Medicare through March each year.³

For the 2019 snapshot profile of all Medicare enrollees we also identified MA and FFS based on the April month of enrollment if available. We looked back from January to March to include any individuals who passed away during that time.

We excluded any enrollees with one or more months of dual eligibility with a state program payer other than Medicaid from 2013 to 2019.

Dual status identification

For the 2013 to 2019 longitudinal study we assigned dual eligible status in the same month we identified Medicare enrollment type. For the 2019 snapshot analysis we assigned dual status to

³ Medicare.gov. Joining a Health or Drug Plan. Retrieved October 2, 2020, from <https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan#>

anyone with a single month of that status. Full or partial dual was assigned based on the plurality of months with dual status. Ties defaulted to the last month of dual enrollment.

Demographics and other characteristics of interest

We summarized demographics and other characteristics as follows:

- Age and gender distribution by age/gender bands
 - Age by year is as of the end of each year
 - Age for joiners and leavers is at the end of each year of transition
 - Age of an individual transitioning multiple times reflects that person's age at each transition so that some individuals are counted more than once
 - Age for full-time stayers is at the end of 2013
 - Any gender identified as "unknown" was censored
- Race and ethnicity was determined from the enhanced field "RTI_RACE," which applies an algorithm based on the first and last name to identify more beneficiaries as Hispanic or Asian. We identified the following race and ethnicity categories:
 - Non-Hispanic White
 - Racial minorities:
 - Hispanic
 - Black (or African American)
 - Asian/Pacific Islander
 - Other
 - American Indian/Alaska Native
 - Unknown

Caveats and Limitations

These results are based on analysis of the 2013-2019 CMS 100% Medicare Research Identifiable Data Set. Different data and time periods can produce different results.

Bruce Pyenson, Catherine Murphy-Barron, Christine Ferro, and Matt Emery are employed by Milliman, Inc. The American Academy of Actuaries requires its members to identify their credentials in their work product. Pyenson, Murphy-Barron, and Emery are members of the American Academy of Actuaries and meet its relevant qualifications.

This report was commissioned by the Better Medicare Alliance, Inc.



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HEARING TESTIMONY
June 24, 2021

Thank you Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chairwoman Eshoo, and Subcommittee Ranking Member Guthrie for the opportunity to provide testimony to the House Committee on Energy and Commerce Subcommittee on Health. I am encouraged by today's focus on legislation to advance equity in public health, and I am honored to have my bill, the Anti-Racism in Public Health Act (H.R. 666), included in this hearing.

I introduced the Anti-Racism in Public Health Act, in partnership with Representative Barbara Lee and Senator Elizabeth Warren, to invest in robust, comprehensive research on the public health impacts of structural racism and policy solutions to bring an end to racial health disparities once and for all. Structural racism is a public health crisis that continues to ravage Black, Brown and indigenous communities, deny us quality health care, and exacerbate the longstanding disparities in health outcomes. My legislation currently has 56 cosponsors and more than 30 organizational endorsements ranging from the Leadership Conference on Civil and Human Rights to the National Medical Association to UnidosUS.

The legislation would create a National Center for Anti-Racism at the Centers for Disease Control and Prevention (CDC) and a Law Enforcement Violence Prevention Program. The newly created Center would recognize racism as a public health crisis and provide dedicated resources to support local and state efforts to educate the public and advance antiracist public health interventions.

The same way the CDC provides guidance to health officials and policymakers related to coronavirus, this legislation would require the CDC to publish and promote anti-racist health policy. We need a robust, multidisciplinary, intersectional, and race-conscious approach that acknowledges decisions on social determinants of health, like housing justice and transportation equity, are major factors in public health outcomes.

In alignment with today's hearing title, "Empowered by Data," the bill puts a premium on data collection that is rooted in community. We need to continue to learn how entrenched structural racism is in our everyday life so that we can fully transform our approach to public health and eradicate racial disparities. Funding is appropriated to conduct research, award grants, and provide leadership and coordination on the science and practice of anti-racism in the provision of health care, the public health impacts of systemic racism, and the effectiveness of interventions to address these impacts. Further, the Anti-Racism in Public Health Act calls for the creation of at least 3 regional centers of excellence in anti-racism under the CDC.

But make no mistake, we already have sufficient data, spanning centuries of research, to treat structural racism like the public health crisis it is. And we must.

Racial disparities in health outcomes exist at alarming rates. Compared to their white counterparts, people of color are more likely to suffer from chronic health conditions, such as diabetes, asthma, and hypertension.¹ Black Americans bear a disproportionate share of the cancer burden, having the lowest survival rate among racial groups for most cancers.² Black, American Indian, and Alaska Native women are two to three times more likely to die from pregnancy-related causes than white women.³ The experiences of countless Black and brown women, including four-time Olympic gold medalist Serena Williams, demonstrate how race, not education or income, determine health outcomes like maternal morbidity.

The nation's current crises underscore how structural racism is contributing to the mortality rates in communities of color, particularly Black people. Due to COVID-19, people of color are dying at higher rates than white people. Black people, across all ages, are at least twice as likely to die from the disease compared to their white counterparts.⁴ The Massachusetts 7th Congressional District, which includes most of Boston, Cambridge, and Chelsea, has been among the hardest hit areas throughout the Commonwealth of Massachusetts. Despite accounting for just 25 and 20 percent of the city's population, Black and Latinx residents made up 65 percent of COVID-19 infections.⁵ These disparities are a direct reflection of how pervasive structural racism and inequality have predisposed communities of color to co-morbidities that heighten the risk of COVID-19 hospitalization and death.

Furthermore, inequitable access to quality health care disproportionately burdens communities of color. Among similarly situated nations, the United States is unique in its failure to guarantee health care as a human right and ensure all people have affordable and comprehensive coverage.⁶ People of color and immigrants are less likely to be insured,⁷ and health care providers are scarce

¹ See Sofia Carnatala & Connor Maxwell, *Fact Sheet: Health Disparities by Race and Ethnicity*, CTR. FOR AM. PROGRESS (May 7, 2020), <https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/>.

² See Carol E. DeSantis et al., *Cancer Statistics for African Americans, 2019*, AM. CANCER SOC'Y (Feb. 14, 2019), <https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21555>.

³ *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL AND PREVENTION (Sept. 5, 2019), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.

⁴ See Tiffany Ford et al., *Race gaps in COVID-19 deaths are even bigger than they appear*, BROOKINGS INST. (June 16, 2020), <https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/>.

⁵ See *Racial Data on Boston Resident COVID-19 Cases*, CITY OF BOS. (July 15, 2020), <https://www.boston.gov/departments/mayors-office/racial-data-boston-resident-covid-19-cases>.

⁶ See Max Fisher, *Here's a Map of the Countries That Provide Universal Health Care (America's Still Not On It)*, ATLANTIC (June 28, 2012), <https://www.theatlantic.com/international/archive/2012/06/heres-a-map-of-the-countries-that-provide-universal-health-care-americas-still-not-on-it/259153/>.

⁷ See Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018*, KAISER FAMILY FOUND. (Mar. 5, 2020), <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>.

in many Black and brown communities, making it difficult to access quality care.⁸ Lack of routine and preventive medical care exacerbates the aforementioned racial disparities of chronic health conditions.

Racial inequity in public health is a result of government-sanctioned policies and practices. People of color are not predisposed to poorer health outcomes due to our race. Racist historical, cultural, institutional, and interpersonal dynamics directly and indirectly affect our health. The long history of codifying racism throughout the United States has lasting health effects.

The Anti-Racism in Public Health Act is a first-of-its-kind bill. It is bold, progressive policy that meets the scale and scope of the crisis we are living in. It is not enough to simply call out racism. In this moment of national reckoning, the federal government has a moral obligation to actively pursue anti-racist policies and dismantle systemic racism once and for all.

This Committee has an opportunity to be intentional and precise in legislating justice and equity by collecting data and taking action on racial disparities in health outcomes. As we begin to turn the page on the COVID-19 pandemic, we cannot simply return to the status quo normal that allowed these inequities to exist because the status quo was never good enough. We must do all that we can to root out racism everywhere it exists, including in our public health system.

A more just and equitable nation is possible.

⁸ See Amelia Goodfellow et al., *Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review*, ACAD. MED. (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007145/>.

[April 30, 2021]

Honorable Xavier Becerra
The U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Becerra:

Congratulations on your recent confirmation to serve as the Secretary of Health and Human Services. We look forward to working together in your new role to ensure the Medicare program continues to provide high-quality, affordable care. For over two decades, Medicare Advantage (MA) has been integral to fulfilling the Medicare guarantee, offering choices, affordability, and meeting the holistic health needs of seniors and those with disabilities, today providing coverage to 42 percent of all Medicare beneficiaries totaling over 26 million seniors.¹

Collectively, we represent more than 6.6 million seniors across 90 Congressional Districts that chose to enroll in MA.² In our districts the majority – over 50 percent, and in some cases over 60 percent – of seniors are enrolled in the program. We write to express our strong bipartisan support for MA and encourage you to protect and strengthen this important choice for seniors in the Medicare program. MA is delivering high-quality, affordable coverage, and is uniquely positioned to ensure seniors receive the care and support they need during the pandemic and beyond while improving health outcomes and advancing health equity for over 26 million seniors.

MA serves a diverse population, 28 percent of beneficiaries are racial and ethnic minorities, as compared to 21 percent in Medicare-Fee-for-Service (FFS). Currently, 55 percent of Latino and 39 percent of African American beneficiaries have actively chosen to enroll in MA and there is growing diversity in enrollment because of the value provided to beneficiaries.³ Furthermore, more than half of MA beneficiaries have low-fixed incomes of less than \$30,000 annually, underscoring the critical need for access to affordable health care coverage.⁴ MA provides financial protections from high out-of-pocket costs not available in Medicare FFS, which is particularly important for approximately 50 percent of seniors enrolled in MA whose incomes fall below 200% of the Federal Poverty Level.⁵ A recent analysis found that beneficiaries in MA are spending nearly \$1,600 less annually out-of-pocket compared to beneficiaries in Medicare (FFS).⁶

Nearly all MA beneficiaries report satisfaction with their health coverage in part because it is focused on diagnosing and treating chronic conditions early to minimize disease progression,

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrollData>

² <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn>

³ https://www.ahip.org/wp-content/uploads/MA_Demographics_Report_2019.pdf

⁴ https://www.ahip.org/wp-content/uploads/MA_Demographics_Report_2019.pdf

⁵ https://bettermedicarealliance.org/wp-content/uploads/2020/04/BMA-FactsSheet_low_modestincomes-003.pdf

⁶ https://bettermedicarealliance.org/wp-content/uploads/2020/04/BMA-FactsSheet_low_modestincomes-003.pdf

avoiding hospitalization, and coordinating care.⁷ MA provides innovative and affordable benefits designed to address social determinants of health that are not available in Medicare FFS including transportation to providers, nutrition services and meal delivery, post-acute care coordination services, dental, vision, hearing, and other wellness benefits.

MA's additional benefits and services are demonstrating results and improving health outcomes. Recent research shows that compared to Medicare FFS, MA beneficiaries are 20 percent more likely to have an annual preventive care visit and have a 52 percent lower rate of complications for beneficiaries with diabetes.^{8,9} Importantly, MA beneficiaries spend less time in the hospital – beneficiaries with chronic conditions experienced 23 percent fewer inpatient hospital stays and 33 percent fewer emergency room visits than similar individuals in Medicare FFS.¹⁰

In response to the COVID-19 pandemic, MA took swift action to protect and support seniors and those with disabilities, including delivering meals, providing personal protective equipment, activating clinical outreach, and enhancing touchpoints with providers through telehealth to keep beneficiaries healthy. MA plans also helped launch a pilot program called Vaccine Community Connectors in March. The program aims to quickly vaccinate seniors through vaccine education, appointment scheduling, transportation services, and partnering with federal, state, and local officials to deliver vaccines to underserved communities. Additionally, crucial financial protections were provided to seniors including waiving co-pays for primary care, telehealth, and COVID-19 medical treatment.

Again, congratulations on your confirmation. We look forward to working with you to protect and strengthen MA for the over 26 million seniors it serves, including the millions of seniors we collectively represent across our Congressional Districts who rely on this critical Medicare program to deliver high-quality, affordable health care that is improving health outcomes and advancing health equity across the country.

Sincerely,

Val Demings
Member of Congress

Mike Gallagher
Member of Congress

Marc Veasey
Member of Congress

Gus Bilirakis
Member of Congress

⁷ https://bettermedicarealliance.org/wp-content/uploads/2021/01/BMA_Seniors-on-Medicare-Memo_.pdf

⁸ Sukyung Chung, Lenard I. Lesser, Diane S. Lauderdale, Nicole E. Johns, Latha P. Palaniappan and Harold S. Luft. Medicare Annual Preventive Care Visits: Use Increased Among Fee-For-Service Patients, But Many Do Not Participate. *Health Affairs*, 34, no.1 (2015):11-20.

⁹ <http://avalere.com/expertise/managed-care/insights/medicare-advantage-achieves-better-health-outcomes-and-lower-utilization-of>

¹⁰ <http://avalere.com/expertise/managed-care/insights/medicare-advantage-achieves-better-health-outcomes-and-lower-utilization-of>



June 23, 2021

The Honorable Anna Eshoo
Chairwoman
Energy and Commerce, Health Subcommittee
United States House of Representatives
Washington, DC, 20515

The Honorable Brett Guthrie
Ranking Member
Energy and Commerce, Health Subcommittee
United States House of Representatives
Washington, DC, 20515

Re: Hearing on “Empowered by Data: Legislation to Advance Health Equity and Public Health”

Dear Chairwoman Eshoo and Ranking Member Guthrie:

Tobacco use is the leading cause of death and disease in the United States.¹ Nearly half a million people die from a tobacco-related illness annually and another 16 million Americans live with a tobacco related disease. The burden of tobacco use disproportionately falls on people of lower socio-economic status, who are more likely to be covered by Medicaid.²

During the COVID-19 pandemic, the need to address health equity became more apparent. The Centers for Disease Control and Prevention (CDC) identified smoking as a high-risk comorbidity relative to COVID-19; smokers (including those who used to smoke) have a much higher risk of developing serious complications due to COVID-19.³ While the pandemic highlighted one way that smoking can exacerbate health issues, COVID-19 is not the only risk smokers face.

The American Lung Association applauds the Subcommittee’s decision to include H.R. 2125, the Quit Because of COVID-19 Act, in Thursday’s hearing, “Empowered by Data: Legislation to Advance Health Equity and Public Health,” as this bill will help reduce health disparities. According to CDC, substantial disparities exist in [smoking rates](#), specifically among Native Americans, lesbian, gay, and bisexual (LGB) individuals, low-income individuals, and the behavioral health population.⁴ Partially due to these disparities, the Medicaid population, in particular, smokes at high rates, more than double their counterparts in private insurance (24.9% vs. 10.7%).⁵ Members of groups that smoke at higher rates are at greater risk of cancer, cardiovascular disease and premature death. Additionally, due to the higher smoking rates, member of these communities and their loved ones are also exposed to secondhand smoke at greater rates. Secondhand smoke causes another 41,000 deaths each year.

Data show that across demographics, including age, insurance status and education level, most smokers want to quit.⁶ However, data also show that not all Medicaid enrollees have access to a comprehensive tobacco cessation benefit.⁷ Currently, 13 states (CA, CO, CT, KS, KY, MA, MN, MO, ME, OH, OR, RI, and SC) provide a comprehensive cessation benefit to all their Medicaid enrollees. The remaining 37 states and DC can improve their coverage.

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In January 2020, Surgeon General Jerome Adams released *Smoking Cessation: A Report of the Surgeon General*.⁸ One of the major conclusions of this report was that “insurance coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services, leads to higher rates of successful quitting, and is cost-effective.” H.R. 2125 would provide this coverage for the millions of individuals enrolled in Medicaid programs across the country.

In 2020, the U.S. Surgeon General found that quitting smoking has many health benefits.⁹ This includes reducing the risk of 13 different types of cancer, including lung cancer, pancreatic cancer and colorectal cancer; reducing the risk of morbidity and mortality from cardiovascular disease; and more.¹⁰ Quitting smoking can also generate significant cost-savings, specifically in terms of healthcare spending. A recent analysis found that 11.7% of healthcare costs (\$225 billion) in the United States are attributable to smoking, with Medicare and Medicaid responsible for more than half of that amount.¹¹ There is a cost to taxpayers of not helping smokers quit. And that cost is growing – Medicaid’s share of those costs is growing: from 2010 to 2014 Medicaid’s share of the smoking attributable healthcare costs grew by 30%.¹²

Helping people quit smoking can reduce the prevalence of smoking-caused disease, save lives and save money. One study estimated that a 1% absolute decrease in states’ smoking rates would result in \$2.5 billion in healthcare savings the following year, with the median state saving \$26 million.¹³ H.R. 2125 targets a population that smokes at a high rate, which would help achieve these outcomes.

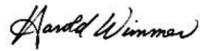
Medicaid enrollees who smoke want to quit at the same rates as their counterparts on private insurance (69.2% vs. 69%), however they quit at lower rates (5.9% vs. 9.4%).¹⁴ H.R. 2125 would provide states with funding to promote the comprehensive cessation benefit created by the bill. This promotion coupled with the expanded benefit would encourage Medicaid enrollees who smoke to make a quit attempt and quit for good.

The American Lung Association is the official source of the Medicaid cessation coverage data for the Centers for Disease Control and Prevention (CDC) and the data source for the Healthy People 2030 metric related to Medicaid’s coverage of tobacco cessation treatment in state Medicaid programs. Based on our experiences collecting these data, we believe this bill is an important step toward helping smokers in the Medicaid program quit. The current patchwork of coverage is not sufficiently conducive to giving all Medicaid beneficiaries across the nation who smoke a real chance to quit.

- First, many states administer their Medicaid programs with managed care organizations (MCOs). The MCOs can change from year to year. Absent state requirements, their coverage of these treatments can vary, resulting in frequent changes in coverage.
- Secondly, a comprehensive tobacco cessation benefit consists of seven medications and three forms of counseling. Three of the seven medications are over-the-counter (OTC) medications. Historically, OTC medications have been excluded from coverage.
- Thirdly, it takes typical smokers between eight and eleven tries to quit successfully. Many state Medicaid programs limit the number of times a person can try to make a quit attempt, and a couple of states limit the total number of tries per lifetime.

The Quit Because of COVID-19 Act can help reduce disparities in tobacco use and tobacco-related disease and death. This bill will save money and save lives. The American Lung Association fully supports its swift passage.

Sincerely,



Harold P. Wimmer
President and CEO

Cc: The Honorable Frank Pallone, Chairman, Committee on Energy and Commerce Committee
The Honorable Catherine McMorris Rodgers, Ranking Member, Committee on Energy and Commerce Committee

¹ U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.

² Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: <http://dx.doi.org/10.15585/mmwr.mm6946a4>

³ Centers for Disease Control and Prevention. COVID-19: People with Certain Health Conditions. May 13, 2021. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

⁴ Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: <http://dx.doi.org/10.15585/mmwr.mm6946a4>

⁵ Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: <http://dx.doi.org/10.15585/mmwr.mm6946a4>

⁶ Babb S, Malarcher A, Schauer G, Asman K, Jamal A. Quitting Smoking Among Adults — United States, 2000–2015. MMWR Morb Mortal Wkly Rep 2017;65:1457–1464. DOI: <http://dx.doi.org/10.15585/mmwr.mm6552a1>

⁷ DiGiulio A, Jump Z, Babb S, et al. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2008–2018. MMWR Morb Mortal Wkly Rep 2020;69:155–160. DOI: <http://dx.doi.org/10.15585/mmwr.mm6906a2>

⁸ U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.

⁹ U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.

¹⁰ Ibid.

¹¹ Xin Xu, Sundar S. Shrestha, Katrina F. Trivers, Linda Neff, Brian S. Armour, Brian A. King, U.S. healthcare spending attributable to cigarette smoking in 2014, *Preventive Medicine*, 2021, 106529, ISSN 0091-7435, <https://doi.org/10.1016/j.ypmed.2021.106529>.

¹² Ibid.

¹³ Glantz SA. Estimation of 1-Year Changes in Medicaid Expenditures Associated With Reducing Cigarette Smoking Prevalence by 1%. *JAMA Netw Open*. 2019;2(4):e192307. doi:10.1001/jamanetworkopen.2019.2307

¹⁴ Babb S, Malarcher A, Schauer G, Asman K, Jamal A. Quitting Smoking Among Adults — United States, 2000–2015. *MMWR Morb Mortal Wkly Rep* 2017;65:1457–1464. DOI: <http://dx.doi.org/10.15585/mmwr.mm6552a1>



Testimony of the National Indian Health Board
“Empowered by Data: Legislation to Advance Equity and Public Health”
United States House of Representatives
Energy and Commerce Committee
Subcommittee on Health
June 24, 2021

Chairwoman Eshoo, Ranking Member Guthrie, and Members of the Subcommittee, thank you for holding this critical hearing *“Empowered by Data: Legislation to Advance Equity and Public Health.”* On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

Background - The Reality of Broken Treaties

We continue to bear witness and experience the alarming obstacles to our everyday lives resulting from this unprecedented crisis. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships, and our personal livelihoods – in some ways, permanently. The past year has been a profoundly uncertain and challenging time; and also, times of profound opportunity to achieve redress of hundreds of years of injustices, which are the children of colonization.

Today, our nation is confronted by the COVID-19 pandemic that continues to disproportionately ravage the most marginalized among us, and Indian Country has been right at the center of the pandemic. In order to understand how to address and overcome these challenges and realize the opportunity for transformation before us, we must first insist on an honest reckoning of our history. The challenges we face today - most recently evidenced through the impacts of COVID-19 on Tribal communities - are the fruits of colonization. This system of exploitation, violence and opportunism is the foundation on which this Nation was constructed. Despite the poor social determinants of health most frequently found in the Indigenous and other communities of color - circumstances that proceed from hundreds of years of colonization - we are often blamed for our poor circumstances. What our communities are experiencing during this COVID-19 pandemic is simply the expected outcome of this historical truth.

Centuries of genocide, oppression, and simultaneously ignoring our appeals while persecuting Our People and our ways of life persist - now manifest in the vast health and socioeconomic inequities we face during COVID-19. The historical and intergenerational trauma our families endure, all rooted in colonization, are the underpinnings of our vulnerability to COVID-19. Indeed, we tell our stories of treaties, Trust responsibility and sovereignty – over and over – and it often appears the listeners are numb to our historic and current truths. But the truth does not change that is the ground we stand on. We hear baseless stories about how “dirty Indians” are causing the outbreaks, or how private hospitals are refusing to accept referrals to treat Our People. These same sentiments echoed across all previous disease outbreaks that plagued Our People from Smallpox to HIV to H1N1. This begs the painful question: what has changed?

The underpinnings of colonization may finally be loosening as a consequence of the exposed neglect, abuse, bad faith, and inequities AI/AN People have experienced during this pandemic. But it did not start with COVID-19. This pandemic and the way it is ravaging our Peoples is exposing the consequences of hundreds of years of US policy predicated on broken promises with the Indigenous Peoples of this land.

Health Inequities Create Additional Risks from COVID-19

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and the outlawing of traditional ways of life, religion and language, the inevitable results are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

Chronic and pervasive health staffing shortages –from physicians to nurses to behavioral health practitioners – stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective, and culturally indifferent, at best – inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care.

Tribal Nations are also severely underfunded for public health and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. And even though Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated as public health authorities in statute, **they continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education.**

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic

mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.¹

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.² In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)³; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

CDC reported that the presence of underlying health conditions such as type II diabetes, obesity, cardiovascular disease, and chronic kidney disease significantly increase one's risk for a severe COVID-19 illness. AI/AN populations are disproportionately impacted by each of these chronic health conditions. For instance, type II diabetes incidence and death rates are three times and 2.5 times higher, respectively, for AI/ANs than for non-Hispanic Whites. Despite significant improvements in rates of End Stage Renal Disease (ESRD) as the result of the highly successful Special Diabetes Program for Indians (SDPI), AI/AN communities continue to experience the highest incidence and prevalence of ESRD.

Increased physical distancing and isolation under the COVID-19 pandemic have led to recent and alarming spikes in drug overdose deaths, suicides, and other mental and behavioral health challenges. Population-specific data on increased drug overdose and suicide deaths during the pandemic are currently unavailable; yet if trends prior to the rise of COVID-19 are any indicator of risk, it is safe to assume that AI/AN People are experiencing serious challenges. One of the major drivers of increased mortality rates among AI/ANs overall has been significantly higher rates of drug overdose and suicide deaths than the general population. So, into this neglected and stunted health system on which American Indians and Alaska Native rely - into this system which is, collectively, the living expression of how seriously the federal government takes Treaty obligations and the Trust responsibility that requires the provision of full and quality health care for American Indians and Alaska Natives - into all of this theatre of failure comes COVID-19.

Policy Recommendations

1. **Expand and Strengthen the Government-to-Government Relationship with the Federal Government and the Tribes/Expand Self-Governance**

¹ South Dakota Department of Health. Mortality Overview. Retrieved from <https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf>

² Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

³ Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

The Indian Health Service (IHS) is the only agency within HHS that retains the authority to establish self-determination contracting or self-governance compacting (as those terms are defined under the Indian Self-Determination and Education Assistance Act) agreements with Tribal Nations and Tribal organizations. However, not all IHS programs are subject to ISDEAA agreements. For example, Tribes are barred from receiving IHS behavioral health grants (i.e., Methamphetamine and Suicide Prevention Initiative/Domestic Violence Prevention Initiative) under ISDEAA agreements. The federal government should commit to working with Tribes to ensure all IHS programs and funds can be allocated to Tribes under ISDEAA agreements.

Tribes also call on the federal government to expand self-determination and self-governance authority across all of HHS. In the interim, the Administration should work with Congressional appropriators to authorize interagency transfer of funds from other HHS operating divisions to IHS, given that IHS is currently the only agency with ISDEAA authority.

As background, in 2000, P.L. 106-260, included a provision directing HHS to conduct a study to determine the feasibility of a demonstration project extending Tribal self-governance to HHS agencies other than the IHS. The HHS study, submitted to Congress in 2003, determined that a demonstration project was feasible. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696 - Department of Health and Human Services Tribal Self-Governance Amendments Act - that would have allowed these demonstration projects. A second study was completed in 2011 by the U.S. Department of Health and Human Services Self-Governance Tribal Federal Workgroup that noted additional legislation would be needed for the expansion. Despite these findings supporting expansion of Tribal self-determination and self-governance, Congress has yet to act legislatively.

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. Self-governance represents efficiency, accountability, and best practices in managing and operating Tribal programs and administering federal funds at the local level. Expanding self-governance translates to greater flexibility for Tribes to provide critical social services within agencies such as the Administration on Aging, the Administration on Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Administration (SAMHSA), and Health Resources and Services Administration (HRSA).

Allowing Tribes to enter into self-governance compacts with HHS and its operating divisions would mean that federal dollars are used more efficiently because resources in Tribal communities, which are often small, could be more easily pooled and would allow Tribes to organize wrap-around services to better serve those who have the greatest need. Self-governance allows Tribes to extend services to larger populations of eligible American Indians and Alaska Natives, leveraging other opportunities more efficiently than the federal government. It also leads to better outcomes because program administrators are in close contact with the people they serve, making the programs more responsive and effective.

- Enact a permanent expansion of Tribal self-determination and self-governance across all agencies within the HHS and affirm that all programs at the IHS are eligible to be contracted and compacted.

- Expand and codify all Tribal Advisory Committees (TAC) to ensure Tribes have a voice within all operating divisions that provide funding to Tribal governments and communities.
- Create direct funding to Tribes and avoid grant mechanisms which cause Tribes to compete against other Tribes or against well-resourced states, cities, and counties.
- Streamline reporting requirements to reduce burdens on Tribal nations receiving funding.

2. Create Set Aside Funding for Tribes in all HHS Operating Divisions

Tribes interact with the various HHS operating divisions on a regular basis and there should be funding dedicated to ensuring that the agencies can meet Tribal needs. In fact, honoring the trust responsibility requires the federal government to meet the needs of Tribal communities. However, the status quo often prevents this from happening. For example, Health Resources and Services Administration (HRSA) frequently gives out grants and conducts programming aimed at rural providers. Unfortunately, the existing framework forces Tribes to compete for these funds, and as a result, Tribes regularly lose out on funding when the system pits them against better resourced states or counties. The work of the various agencies can be improved if Congress allocated base funding directly for the Tribes.

- Create set aside funding for Tribes in the annual appropriation for each HHS operating division.
- Ensure funding can flow to Tribes through self-determination contracting and self-governance compacting, and that Tribes have maximum flexibility and minimum administrative burden. Ensure funding can be allocated through a formula to all Tribes, and not as competitive grants.
- Wherever possible, each agency should use administrative authorities to create set aside funding for Tribes.
- Each agency should devise a formula, through Tribal consultation, to ensure it allocates funding in an equitable manner.
- Each agency should conduct Tribal consultation on a yearly basis, at a minimum, so the agency can include Tribal requests and recommendations in the agency's budget request to Congress.

3. Ensure Tribal Access to Data and Support Tribal Data Sovereignty

Recent federal scientific initiatives through the National Institutes of Health (NIH) and the Food and Drug Administration (FDA), have sought Tribal leaders' endorsement of their projects in Indian Country. While Tribal advocates support the development of scientific initiatives to prevent and cure diseases, Tribes are sovereign nations and are the ultimate stewards and owners of the data collected on their Tribal citizens.

The Centers for Disease Control and Prevention (CDC) must work collaboratively with Tribes to ensure that Tribes have access to their Tribal data. Understanding and honoring Tribal data sovereignty must be the cornerstone of all CDC Tribal data collection efforts. Doing

so will improve overall public health data reporting and provide the most accurate information for developing budget and public health priorities, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development and evaluation.

Structural challenges in data reporting only serve to render invisible the disparate impact of COVID-19 in Indian Country. For example, TECs continue to face significant barriers in exercising their statutory public health authorities by facing major hurdles in accessing federal and state public health surveillance systems, including for COVID-19, which often has incomplete or inaccurate race/ethnicity data. In addition, not every state, city and county jurisdiction include AI/AN as a distinct demographic on health assessment and surveillance forms, often lumping them under “other.” These race/ethnicity data gaps contribute to ongoing underestimates that only further obscure the true burden of COVID-19 and other diseases for AI/ANs. Furthermore, Tribes often experience significant barriers in accessing the patchwork of state infectious disease tracking and reporting systems. This must be corrected to allow the Tribes access to their own data in a timely manner.

While available data demonstrates higher rates of health disparities among AI/ANs in a variety of health conditions, estimates of disease prevalence and incidence for AI/ANs are likely to be underestimates due to high rates of racial misclassification and undercounting of AI/AN populations in state and federal surveillance systems. A comprehensive plan to address the gaps in data collection across these surveillance systems is drastically needed to improve the information readily available to Tribal leaders to better inform their public health policies and programs.

Unfortunately, because of high rates of misclassification and under-sampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the impact of COVID-19 in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19, however, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities. Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York, and California continue to report thousands of COVID-19 cases without any information on patient race/ethnicity or categorizing cases as “other” on demographic forms. ***In California, for instance, the state noted they lack race/ethnicity data for nearly 30% of reported cases.*** Multiple studies demonstrate that surveillance systems frequently misclassify AI/ANs or omit them from surveillance systems entirely. These issues continue exacerbate health disparities including those from COVID-19.

The CDC must work with state and local health departments, community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), IHS facilities, Tribally-run health facilities, and Tribal Epidemiology Centers (TECs) to ensure that complete and accurate data is captured and shared with Tribes so they can effectively respond and recover from COVID-19, and other similar public health emergencies. Timely and accurate data play a vital role in public health decision-making, and would allow for better, data-driven Tribal public health policy, which would better protect Tribal members.

4. Create Set-Aside Funding for Tribes Throughout the CDC and Invest in Tribal Public Health Systems

Tribes interact with the CDC on a regular basis and there should be funding dedicated to ensuring that the agencies can meet unique Tribal needs. Unfortunately, the status quo often prevents the fulfillment of Tribal needs. For example, CDC frequently distributes funding via competitive grants and conducts programming aimed at strengthening Tribal public health infrastructure and systems, but these methods of funding do not allow for equitable funding across all Tribal public health systems.

Dedicated funding for Tribes and Tribal organizations is the most effective way to ensure that adequate resources are reaching Indian Country, while also furthering the fulfillment of the federal government's trust responsibility for health. With Good Health and Wellness in Indian Country (GHWIC) as a potential model, CDC should consult with Tribes to design and fund Tribal public health infrastructure and capacity development initiative in Indian Country with the flexibility to permit Tribes to tailor programs to their unique community priorities. The CDC must commit to these direct Tribal investments that support Tribes in addressing public health development and other issues. **There should be a minimum of 5% set-aside for Tribes across all CDC Centers, Institutes, and Offices (CIOs) to meaningfully begin to build equitable Tribal public health systems, compared to states and local health departments.** This funding will help integrate Tribal public health needs and priorities across the entire CDC and all CDC programs. For those CDC CIOs that do not send funding out as grants, **at least 5% of funding resources for internal activities should be directed and dedicated to Tribal support.**

5. End the Competitive Grant Process for Tribes

At the core of the federal trust responsibility to Tribal Nations is the fact that the federal government is supposed to ensure the health and welfare of Native peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold their end of the bargain in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly running into systemic barriers that impede their ability to actually receive help from the federal government and this is slowing or even outright denying access to aid.

One reason is because in all but the latest COVID-19 relief packages, the federal government decided to use competitive grant making as a means of distributing funds to Tribes. To apply for competitive grants, you need staff to put together an application. Tribes that were lower resourced found themselves having to use a skeleton staff to put together applications to have access to funds that they needed to provide care for their people. If Tribes could not pull together these resources, they were excluded from being able to apply for these pots of money.

Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. **The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the**

quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under. That is unacceptable.

Instead, a more effective way to distribute aid to Tribes would be through a fixed funding formula that ensures sufficient, recurring, sustainable funding reaches all Tribal Nations. Doing so would allow Tribes to know that the funding was coming to them, how much they were getting, and be able to plan to utilize that money to help their citizens. It would have also alleviated the burden on Tribes to use their staff to apply for grant funding and allowed them to use their limited resources to treat the issue at hand. We were pleased, for the first time, Congress provided a dedicated, standalone section to Indian health in the American Rescue Plan. This type of mechanism in the law is precisely what Indian Country has been asking for and avoids competitive grants altogether.

While Tribes may be eligible for competitive grants addressing public health and other issues, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to apply and/or compete for the grants. Moreover, **Tribal eligibility for funding does not equate to Tribal access**, especially when Tribes are forced to compete with states, cities, and other governments that are generally higher resourced. In short, the federal government must cease using the competitive grant mechanism to try to fulfill its trust obligations to Tribal Nations. It is essential that HHS make a major commitment to creating set-asides for direct funding to Tribal governments and organizations in a streamlined, non-competitive, sustainable, and equitable fashion.

Another issue was the insufficient notice of funding opportunities. Many Tribes were not told what opportunities were available or how they would be able to access the funding. Given the Trust Responsibility, we would expect HHS to take special care to ensure that Tribes know of these opportunities and are able to submit any required documentation within a timely manner. Tribes were also forced to deal with agencies with whom they had little experience or knowledge. For example, in the initial funding allocations, aid to Tribes was distributed through the CDC and not IHS. This, in turn, created a delay in receiving funding as the CDC had to create a mechanism to either distribute the funding themselves or transfer the money to IHS. However, in the American Rescue Plan, funds were directed to flow through IHS, who already has an existing relationship with Tribes to release these funds more efficiently and effectively.

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were largely left behind during the nation's development of its public health infrastructure and systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind those of most state, territorial, and even city and county public health entities in terms of their capacity. This includes core services, such as disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. Additionally, HHS must commit the resources and CDC must continue its meaningful and sustainable direct investments into Tribal communities for public health if we are ever to close the gap in the disparities of lower health status, and lower life expectancy of AI/AN Peoples compared to the general population.

Conclusion

Our treaties stand the test of time. They are the Supreme Law of this land. If a nation's honor and exceptionalism is a measure of its integrity to its own laws and creed, then one must look no further than the United States' continued abrogation of its own treaties to recognize that its honor is in short supply. Every square inch of this nation is Our People's land. As the sole national organization committed to advocating for the fulfillment of the federal government's trust and treaty obligations for health, we will always be dedicated to bringing into fruition the day where Our People can state with dignity that the United States held true to its solemn word. Ideally, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its promises. These lands and natural resources, most often acquired from us shamefully, are the bedrock of U.S. wealth and power today.

In closing, we thank the Committee for the continued commitment to Indian Country and urge you to further prioritize Indian Country as you continue to provide relief regarding the COVID-19 pandemic. We patiently remind you that federal treaty obligations to the Tribes and AI/AN People exist in perpetuity and must not be forgotten during this pandemic. We thank you that American Indians and Alaska Natives will continue to be prioritized to receive the vaccine, have sufficient funds to build and maintain a public health infrastructure, and the full faith and confidence of the United States Government will further be committed to this nation's first citizens to eradicate this disease. As always, we stand ready to work with you in a bipartisan fashion to advance health in Indian Country.



Comments Submitted for the Record

House Committee on Energy and Commerce
Subcommittee on Health
June 23, 2021

**Dr. Jim Jirjis, Chief Health Information Officer, HCA Healthcare
Member, Health Information Technology Advisory Committee (HITAC)**

Thank you for the opportunity to provide a statement for inclusion in the hearing record. I applaud the Energy and Commerce Committee for its important work to modernize our public health data infrastructure, including ensuring appropriate collection and use of data related to health inequities. I look forward to working with the committee and its members to foster a successful transition from current state to a modern, efficient, and effective system of public health data systems and infrastructure.

HCA Healthcare is one of the nation's leading providers of healthcare services, with over 180 hospitals in 20 states and the United Kingdom. Each year, approximately five percent of all hospital services in the U.S. happen at an HCA Healthcare facility. Last year, HCA Healthcare facilities witnessed over 32 million patient encounters and treated over 170,000 inpatients with COVID-19. HCA Healthcare is also the largest provider of Medicaid services in the country. Twenty-five percent of all hospital admissions and 50 percent of all ER visits in HCA Healthcare facilities either are covered by Medicaid or are uninsured patients.

HCA Healthcare is a strong advocate for the interoperability of health data, including public health data. With our presence in 20 states, we have a unique vantage point that allows us to identify opportunities and gaps to help inform the national roadmap. Internal investment across HCA Healthcare facilities on standardization of our data can serve as a model for how data and interoperability can benefit the health system. By using two key examples of HCA Healthcare's experience with public health emergencies, I recommend the committee focus on three key goals as it works to modernize public health data collection, reporting, and use:

1. Standardization – public health data should adhere to existing, private-sector-driven standards that allow machine-readable and human-understandable information to follow the patient without special effort.
2. Simplification – streamline the complex system of public health reporting to ease burdens on both providers (reporters) and states, local, and tribal jurisdictions (receivers) and ensure accurate and consistent reporting and availability of data.
3. Share – data reported up to public health agencies should not go into a black box. Instead, aggregate data should be shared with providers and others in the field to inform local and

regional decision making and foster collaboration between private entities and between government and the private sector.

COVID-19 Reporting

Complying with COVID-19 reporting required appointment of a “data steward” at each HCA Healthcare facility across the country. We found that we needed a person at each facility making sure that data from different departments was consistently collected and reported up to public health entities. Much of the data required manual reporting, so phone calls or walking around to rooms in a hospital to count gloves were common activities overseen by each data steward. Reporting lab test results was challenging. Initially there was not a specified code in the Logical Observation Identifiers Names and Codes (LOINC) terminology, so we had to figure it out ourselves. Because different COVID-19 tests reported results in different ways, calling to confirm results was common practice. To properly report the 1,605,000 lab tests performed in our facilities and the 335,000 tests our patients received in other facilities, our staff had to map 219 different mnemonics from the 225 laboratories we worked with into 2 LOINC codes. Even now, though LOINC codes are available, as a rule the laboratories do not adhere and still send test results with their own proprietary mnemonics.

The reporting itself was also a major challenge. For federal COVID-19 reporting, each of our 185 hospitals initially had to report individually through the National Healthcare Safety Network (NHSN) up to the Department of Health and Human Services (HHS)—a very inefficient process. Implementation of TeleTracking streamlined federal reporting for us, providing a single source rather than the varied reporting to different public health departments across the country through NHSN. However, in some instances the states themselves report COVID-19 data to HHS and we often have no receipt or confirmation that the data was then sent reliably to HHS. In fact, in many instances data was lost, putting hospitals at risk of appearing non-compliant.

Each public health department in each state in which HCA Healthcare operates has a different data use agreement our facilities must sign in order to share data. Additionally, even if a facility reports up to a state or local authority, there is no guarantee that information will be passed on or received by that entity.

In summary, reporting was incredibly burdensome for providers across our facilities but we were able to make rapid changes across the health system to meet the requirements. There was inconsistent implementation of report collection systems, leading to the need for individual contracting and technical troubleshooting between each end point involved. The lack of consistent standards contributed to this complexity, and all of this created high costs and significant personnel needs for compliance at each facility. By normalizing the variation across the country in both the technical requirements and standards as well as the legal agreements necessary between reporters and receivers, the federal government could ease burdens for both providers and public health authorities and reduce compliance costs. Additionally, the data shared with public health authorities in a crisis like the COVID-19 pandemic should be aggregated and shared back with providers on the ground to inform care decisions and resource allocation with the goal of improving patient outcomes.

Hurricanes

A relevant and prime example of how readily-available, standardized information contained within interoperable systems can be used to solve complex issues can be found in HCA Healthcare's response to the most challenging natural disasters. Forty percent of HCA Healthcare hospitals are routinely in the path of hurricanes. When hurricanes hit Florida a few years ago, our system was put to the test. While electronic health records are primarily focused on day-to-day transactional data documenting the encounters between providers and patients, the systems had to be leveraged to inform our disaster response. By implementing population-level data aggregation, real-time analytics, and clinical decision support, HCA Healthcare was able to assess patient risk and organize patient transports to facilities out of harm's way as needed. Historically prior to the data being mapped and available, that data had to be collected by nurse managers in 47 hospitals in the midst of a hurricane while moving rapidly throughout their hospitals recording the information on paper clipboards.

We were able to develop a risk assessment tool, Next-Gen Analytics for Treatment and Efficiency (NATE), to determine patient acuity, identify the most appropriate mode of transportation, deploy the necessary resources to the right locations, and get patients safely out of the path of the storm.

Thank you for the opportunity to submit comments for the record. In my role as Chief Health Information Officer at HCA Healthcare and as a Member of the Health Information Technology Advisory Committee (HITAC), I am committed to bolstering the exchange of health data to support improved health outcomes. I appreciate the committee's attention to this important matter and look forward to partnering as patient-driven solutions to improve the public health data infrastructure are contemplated.

Congress of the United States
Washington, DC 20515

June 17, 2021

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Charles E. Schumer
Majority Leader
United States Senate
Washington, DC 20510

Dear Speaker Pelosi and Majority Leader Schumer:

As you begin work on the next phase of developing a recovery package, we urge you to include policies to end our nation's maternal mortality crisis and eliminate racial and ethnic disparities in maternal health outcomes. Fifteen months into a global pandemic that has disproportionately harmed communities of color, the risks facing Black women and other birthing people of color are at a crisis point. Any recovery package that will successfully and meaningfully address the pandemic's impact on people of color must directly address the effects of coronavirus disease of 2019 (COVID-19) on pregnant people and new moms. Specifically, we urge you to include the full \$3 billion called for in President Biden's plan to address our maternal health crisis, as well as a permanent expansion of yearlong postpartum Medicaid coverage for every mother in every state.

As you know, the United States has the highest maternal mortality rate of any high-income country and the only rate that is rising. The pregnancy-related mortality rate for Black women in the U.S. is three to four times higher than the rate for white women,¹ and other women and birthing people of color also face elevated rates of mortality and morbidity.²

The risks for pregnant people have only grown during COVID-19: according to the Centers for Disease Control and Prevention (CDC), "pregnant and recently pregnant women are at an increased risk for severe illness from COVID-19 compared to nonpregnant women."³ CDC also found that pregnant people with COVID-19 are at an increased risk for adverse pregnancy outcomes.⁴ In addition to clinical risks, the pandemic has affected social determinants of health

¹ National Institutes of Health Office of Research on Women's Health: *Maternal Morbidity and Mortality*. 2019.

² Centers for Disease Control and Prevention: *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*. September 6, 2019.

³ Centers for Disease Control and Prevention: *Investigating the Impact of COVID-19 during Pregnancy*. <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/special-populations/pregnancy-data-on-covid-19/what-cdc-is-doing.html>. Accessed June 4, 2021.

⁴ Ibid.

that contribute to maternal health disparities, like increased food insecurity, which disproportionately impacts Black and Hispanic families.⁵ Without bold and immediate action to address the heightened clinical and non-clinical threats to pregnant people and their growing families, our national recovery from COVID-19 will only exacerbate the inequities that existed before the pandemic and worsened over the past year.

Recognizing the urgent need to address these alarming trends, President Biden's American Families Plan includes a much-needed \$3 billion investment in maternal health.⁶ The President's proposal provides an opportunity to make considerable investments in federal funding to address this crisis, including policies included in the *Black Maternal Health Momnibus Act of 2021* ([H.R. 959/S. 346](#)) and a permanent expansion of yearlong postpartum Medicaid coverage. By advancing these two priorities in the upcoming recovery package, we can comprehensively address every driver of our nation's maternal health crisis.

Taking bold action to address maternal mortality in the next legislative package builds on important progress we made under your leadership through the *American Rescue Plan Act of 2021*, which included a provision to create a pathway for states to extend postpartum Medicaid coverage from the current standard of 60 days to one full year after the end of a pregnancy. This historic step will allow new mothers to access the care they need and deserve for the full postpartum period. However, the state plan option to extend postpartum coverage in the American Rescue Plan Act expires in five years. We cannot afford to take coverage away from new moms at a time when they need it most: we must include legislation like the *MOMMA's Act* ([H.R. 3407/S. 411](#)) and the *MOMMIES Act* ([H.R. 3063/S. 1542](#)) to make yearlong postpartum Medicaid coverage a permanent reality for every mom in every state in the next recovery package.

It is also essential that the upcoming legislative package includes provisions that target the multifaceted causes of our nation's maternal mortality crisis, such as those in the Momnibus, a suite of 12 essential bills that include bipartisan policies to save moms' lives, end racial and ethnic disparities, and achieve true equity and justice for all mothers and birthing people.

The Momnibus includes investments that will be needed during and after the COVID-19 pandemic, including investments in community-based organizations, policies to grow and diversify the perinatal workforce, expanded access to maternal mental health care treatments and support, measures to address the impacts of climate change on maternal and infant health outcomes, and provisions to protect pregnant people during this pandemic and future public health emergencies. These provisions build on other critical policies, like the investments in evidence-based national obstetric emergency protocol, CDC technical guidance on best practices in maternal mortality and morbidity prevention, and standardized maternal health data collection in the MOMMA's Act.

Permanently expanding postpartum Medicaid coverage and advancing policies in the Momnibus are necessary investments that will save lives, promote health equity, and advance the

⁵ Wolfson & Leung: Food Insecurity During COVID-19: An Acute Crisis With Long-Term Health Implications. November 12, 2020.

⁶ The White House: *American Families Plan*. <https://www.whitehouse.gov/american-families-plan/>. Accessed on June 2, 2021.

fundamental principle that in America, every family has a right to thrive—a principle that begins with a safe and healthy pregnancy and birth. We look forward to working with you to advance this urgent priority.

Sincerely,

Cory A. Booker United States Senator	Lauren Underwood Member of Congress	Robin L. Kelly Member of Congress
Alma S. Adams, Ph.D. Member of Congress	Richard J. Durbin United States Senator	Lisa Blunt Rochester Member of Congress
Jan Schakowsky Member of Congress	Lucy McBath Member of Congress	Anthony G. Brown Member of Congress
Henry C. "Hank" Johnson, Jr. Member of Congress	Al Lawson Member of Congress	Ritchie Torres Member of Congress
Carolyn B. Maloney Member of Congress	Earl Blumenauer Member of Congress	Eddie Bernice Johnson Member of Congress
Gwen Moore Member of Congress	Ayanna Pressley Member of Congress	Mike Quigley Member of Congress
Rashida Tlaib Member of Congress	André Carson Member of Congress	Marc Veasey Member of Congress
Angie Craig Member of Congress	Nydia M. Velázquez Member of Congress	Barbara Lee Member of Congress

Danny K. Davis Member of Congress	Eleanor Holmes Norton Member of Congress	Gerald E. Connolly Member of Congress
Sharice L. Davids Member of Congress	Nanette Diaz Barragán Member of Congress	Joyce Beatty Member of Congress
Darren Soto Member of Congress	Raúl M. Grijalva Member of Congress	Mary Gay Scanlon Member of Congress
Marilyn Strickland Member of Congress	Haley Stevens Member of Congress	Ted Deutch Member of Congress
Terri A. Sewell Member of Congress	Karen Bass Member of Congress	Peter Welch Member of Congress
Jerrold Nadler Member of Congress	Tony Cárdenas Member of Congress	G. K. Butterfield Member of Congress
Bonnie Watson Coleman Member of Congress	Steve Cohen Member of Congress	Brenda L. Lawrence Member of Congress
Albio Sires Member of Congress	Susan Wild Member of Congress	Juan Vargas Member of Congress
Joaquin Castro Member of Congress	Mark DeSaulnier Member of Congress	Carolyn Bourdeaux Member of Congress
Gregory W. Meeks Member of Congress	James E. Clyburn Member of Congress	Hakeem Jeffries Member of Congress
Colin Allred Member of Congress	Dwight Evans Member of Congress	Jackie Speier Member of Congress

Julia Brownley Member of Congress	Tammy Baldwin United States Senator	Lori Trahan Member of Congress
Jamie Raskin Member of Congress	Mondaire Jones Member of Congress	Jason Crow Member of Congress
Madeleine Dean Member of Congress	Donald M. Payne, Jr. Member of Congress	Lizzie Fletcher Member of Congress
Thomas Suozzi Member of Congress	Paul Tonko Member of Congress	Judy Chu Member of Congress
Mike Doyle Member of Congress	Mark Pocan Member of Congress	Ann Kirkpatrick Member of Congress
Jake Auchincloss Member of Congress	John P. Sarbanes Member of Congress	Bennie G. Thompson Member of Congress
David Trone Member of Congress	Alexandria Ocasio-Cortez Member of Congress	Yvette D. Clarke Member of Congress
Alan Lowenthal Member of Congress	Cori Bush Member of Congress	C. A. Dutch Ruppersberger Member of Congress
Ann McLane Kuster Member of Congress	Abigail D. Spanberger Member of Congress	Kathy Castor Member of Congress
Jahana Hayes Member of Congress	Derek Kilmer Member of Congress	Cheri Bustos Member of Congress
Chris Van Hollen United States Senator	Tina Smith United States Senator	Elizabeth Warren United States Senator

Michael F. Bennet United States Senator	Kirsten Gillibrand United States Senator	Tammy Duckworth United States Senator
Ilhan Omar Member of Congress	Frank J. Mrvan Member of Congress	Betty McCollum Member of Congress
Debbie Dingell Member of Congress	Debbie Wasserman Schultz Member of Congress	Elaine G. Luria Member of Congress
Marie Newman Member of Congress	Steven Horsford Member of Congress	Frederica S. Wilson Member of Congress
David Scott Member of Congress	Jim Cooper Member of Congress	Mark Takano Member of Congress
Sanford D. Bishop, Jr. Member of Congress	Sara Jacobs Member of Congress	Al Green Member of Congress
Mike Levin Member of Congress	Eric Swalwell Member of Congress	Kim Schrier, M.D. Member of Congress
James P. McGovern Member of Congress	Grace Meng Member of Congress	Jerry McNerney Member of Congress
Lois Frankel Member of Congress	Kathleen M. Rice Member of Congress	Joseph D. Morelle Member of Congress
Nikema Williams Member of Congress	Seth Moulton Member of Congress	Tim Ryan Member of Congress
Troy A. Carter, Sr. Member of Congress	Ruben Gallego Member of Congress	Suzanne Bonamici Member of Congress

Adriano Espaillat Member of Congress	Adam Smith Member of Congress	Ro Khanna Member of Congress
Mikie Sherrill Member of Congress	Emanuel Cleaver, II Member of Congress	Tom Malinowski Member of Congress
Zoe Lofgren Member of Congress	John B. Larson Member of Congress	Rick Larsen Member of Congress
A. Donald McEachin Member of Congress	Joe Neguse Member of Congress	Bradley S. Schneider Member of Congress
David N. Cicilline Member of Congress	William R. Keating Member of Congress	Amy Klobuchar United States Senator
Tim Kaine United States Senator	Richard Blumenthal United States Senator	Chris Pappas Member of Congress
Kathy E. Manning Member of Congress	Conor Lamb Member of Congress	Adam Schiff Member of Congress
Val Demings Member of Congress	Chellie Pingree Member of Congress	Charlie Crist Member of Congress
Jennifer Wexton Member of Congress	Jamaal Bowman Member of Congress	Raja Krishnamoorthi Member of Congress
Bill Foster Member of Congress	Bobby L. Rush Member of Congress	Edward J. Markey United States Senator
Sherrod Brown United States Senator	Dianne Feinstein United States Senator	Cindy Axne Member of Congress

J. Luis Correa
Member of Congress

Chrissy Houlahan
Member of Congress

Sheila Jackson Lee
Member of Congress

Dean Phillips
Member of Congress

Diana DeGette
Member of Congress

Veronica Escobar
Member of Congress

Sean Casten
Member of Congress

Maxine Waters
Member of Congress

Peter DeFazio
Member of Congress

Andy Levin
Member of Congress

Antonio Delgado
Member of Congress

.....
(Original Signature of Member)

117TH CONGRESS
1ST SESSION

H. R. _____

To amend title XVIII of the Social Security Act to expand the availability of supplemental benefits to certain Medicare Advantage enrollees.

IN THE HOUSE OF REPRESENTATIVES

Mr. BILIRAKIS introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to expand the availability of supplemental benefits to certain Medicare Advantage enrollees.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Addressing Social De-
5 terminants in Medicare Advantage Act of 2021”.

1 **SEC. 2. EXPANDING THE AVAILABILITY OF SUPPLEMENTAL**
2 **BENEFITS TO CERTAIN MEDICARE ADVAN-**
3 **TAGE ENROLLEES.**

4 (a) IN GENERAL.—Section 1852(a)(3)(D) of the So-
5 cial Security Act (42 U.S.C. 1395w–22(a)(3)(D)) is
6 amended—

7 (1) in the header, by striking “CHRONICALLY
8 ILL” and inserting “CERTAIN”;

9 (2) in clauses (i) and (ii), by striking “chron-
10 ically ill” each place such term appears and insert-
11 ing “specified” in each such place; and

12 (3) in clause (iii), by amending such clause to
13 read as follows:

14 “(iii) SPECIFIED ENROLLEE DE-
15 FINED.—In this subparagraph, the term
16 ‘specified enrollee’ means an enrollee in an
17 MA plan that—

18 “(I) the Secretary determines—

19 “(aa) has one or more co-
20 morbid and medically complex
21 chronic conditions that is life
22 threatening or significantly limits
23 the overall health or function of
24 the enrollee;

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3

1 “(bb) has a high risk of hos-
2 pitalization or other adverse
3 health outcomes; and

4 “(cc) requires intensive care
5 coordination;

6 “(II) is a low-income enrollee (as
7 specified by the Secretary); or

8 “(III) meets any other criterion
9 determined appropriate by the Sec-
10 retary, such as criteria relating to so-
11 cial and socioeconomic risk.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply with respect to plan years begin-
14 ning on or after January 1, 2023.



**Written Submission of Sinsi Hernández-Cancio
Vice President for Health Justice
National Partnership for Women & Families**

**"Empowered by Data: Legislation to Advance Equity and Public Health"
House Committee on Energy & Commerce Subcommittee on Health**

Dear Chairwoman Eshoo and Ranking Member Guthrie,

The National Partnership is a nonprofit, nonpartisan advocacy organization working to improve the lives of women and families by achieving equity for all women. In our fiftieth year, the National Partnership continues to fight for health and economic justice. I write in support of today's important health equity legislation and urge the Committee to move these bills to drive more targeted action on addressing our nation's persistent racial, ethnic, and gender health inequities.

As a national expert on health equity and health system transformation, I also encourage the Committee to explicitly name and prioritize seeking solutions for a key driver of adverse social determinants of health – racism. The COVID pandemic highlighted not only the deep racial and ethnic inequities in health outcomes that have persisted throughout our nation's history, it also clearly demonstrated the role of socioeconomic factors in increasing or reducing the risk of disease, and that these risks are concentrated in communities of color.

Strategies to improve adverse social determinants of health that do not intentionally address the impacts of interpersonal and systemic racism on social determinants will have limited effect. We must stop using the language of social determinants of health as a proxy for grappling with racism – as too often happens in health policy conversations. We cannot afford to sidestep this issue anymore. We commend the Committee for holding this hearing today on legislation that directly addresses racism in public health such as the Anti-Racism in Public Health Act and two important pieces of the Black Maternal Health Momnibus.

I have attached a recent report I co-authored with Dr. Joia Crear-Perry, "Saving the Lives of Moms and Babies: Addressing Racism and Socioeconomic Influencers." Our [Saving the Lives of Moms and Babies series](#) was created to provide decisionmakers with a better understanding of how different socioeconomic needs, which are driven by racism and other structural inequities, affect the health of pregnant people and their infants, and to provide concrete recommendations about how to address these

needs. We encourage you to continue to advance the comprehensive policies needed so we can all thrive.

Sincerely,

Sinsi Hernández-Cancio
Vice President for Health Justice
National Partnership for Women & Families

6/24/2021

New Report Ends Corporate Media's Favorite False Narrative About Florida's Successful COVID-19 Response

The COVID-19 Call Center is available 24/7
 1 (866) 779-6121 | COVID-19@flhealth.gov
 For Important Updates Text FLCOVID19 to 888-777



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[Governor Ron DeSantis Appoints Matthew Bruno as Chair and Chereen Coile to the Early Learning Coalition of Miami-Dade/Monroe Board of Directors Governor Ron DeSantis Makes Two Judicial Appointments](#)

New Report Ends Corporate Media's Favorite False Narrative About Florida's Successful COVID-19 Response

On May 14, 2021, in [News Releases](#), by Staff

The "Florida COVID-19 Whistleblower" Story: Media Myths vs. Facts

Tallahassee, Fla. — Florida's COVID-19 death rate is lower than the national average — without draconian lockdowns, unscientific mask mandates, or invasive vaccine passports. To discredit Governor Ron DeSantis' successful response to the COVID-19 pandemic, the corporate media has embraced an absurd narrative for the past year, claiming that "Florida is manipulating COVID-19 data to hide the real numbers."

The single source for this conspiracy theory was a disgruntled former employee of the Florida Department of Health. Though there was zero evidence of data manipulation, partisan media activists did not let the facts derail their false narrative. But yesterday, after reviewing hundreds of pages of public records, [National Review published a comprehensive exposé](#) that destroyed this year-long corporate media smear campaign against Governor DeSantis and Florida's hardworking public health leaders.

Journalists have one job: to report the truth. That so many amplified an obvious lie, solely to score political points, is an indictment of modern journalism.

MEDIA MYTH:

- ["Florida Dismisses A Scientist For Her Refusal To Manipulate State's Coronavirus Data."](#) Greg Allen, *NPR*
- ["As Florida re-opens, COVID-19 data chief gets sidelined and researchers cry foul."](#) Alessandro Marazzi Sassoon, *Florida Today*
- ["Florida fired its coronavirus data scientist. Now she's publishing the statistics on her own."](#) Marisa Iati, *The Washington Post*
- [Other corporate media personalities who parroted this myth: CNN's Chris Cuomo, MSNBC's Lawrence O'Donnell, CBS News' Elaine Quijano](#)

THE FACTS: Rebekah Jones was not Florida's "COVID-19 data chief," nor was she a "data scientist." Jones couldn't have manipulated data — even if she had been asked to — because, according to *National Review*, "Jones did not have the ability to edit the raw data. Only a handful of people in Florida are permitted to touch that information, and Jones was not among them. Instead, each day she was given a copy of the data and charged with uploading it into the system in a manner determined by the epidemiological team."

MEDIA MYTH: ["A public health employee predicted Florida's coronavirus catastrophe — then she was fired."](#) Alexander Nazaryan, *Yahoo News*

THE FACTS: There was never a "coronavirus catastrophe" in Florida. The numbers are in: Governor DeSantis' policies, protecting high-risk groups while letting Floridians freely live their lives, have proven to be the right approach. If the national COVID-19 death rate was as low as Florida's, more than 50,000 Americans would still be alive today. The real "coronavirus catastrophe" was in New York, Pennsylvania, and Michigan, where governors sent COVID-positive patients back to long-term care facilities, resulting in thousands of deaths. California also had a "coronavirus catastrophe": Six months into the state's tyrannical lockdown, more than 40,000 small businesses had closed. Today, California's unemployment rate is nearly twice as high as Florida's.

Corporate media failed to scrutinize negligent pandemic policies in these states, instead elevating outlandish conspiracy theories to attack Governor DeSantis. Sadly, many fell for this deception. According to *National Review*, "by pointing to her own, privately run dashboard, which shows numbers that make Florida's COVID response look worse than it has been, [Jones] has caused millions of people to believe quite sincerely that the state's many successes during the pandemic have been built atop fraud."

MEDIA MYTH:

<https://www.flgov.com/2021/05/14/new-report-ends-corporate-medias-favorite-false-narrative-about-floridas-successful-covid-19-response/>

1/4

6/24/2021

New Report Ends Corporate Media's Favorite False Narrative About Florida's Successful COVID-19 Response

- [“Rebekah Jones, the data official behind Florida's Covid-19 dashboard, was removed after she questioned the data's transparency, according to Florida Today. Now she has launched her own dashboard, which reports different numbers.” CNN New Day](#)
- [“Florida's COVID death count under new scrutiny...Impact of COVID-19 on mortality 'significantly greater' than data suggest.” Scott Sutton, WPTV](#)

THE FACTS: *National Review* reported, “As Jones herself confirmed on Twitter: ‘I use DOH’s data. If you access the data from both sources, you’ll see that it is identical.’ She just... displays them badly. In order to increase the numbers in Florida’s case count, Jones counts positive antibody tests as cases.” Per the Federal Drug Administration (FDA), antibody tests are not used for a diagnostic test. Likewise, Jones claims that Florida is hiding deaths because it does not include non-residents in its headline numbers. In fact, Florida reports non-residents pursuant to CDC guidelines, which say that individuals should be counted according to their state of residency. To be clear, the data that she claims is “wrong” is the exact same data that she herself uses on her dashboard. The difference? Jones includes presumed deaths and out of state cases that are not, according to the CDC, to be attributed to Florida.

MEDIA MYTH:

- [“The *Forbes* Technology Person Of The Year: Rebekah Jones. The data scientist responsible for Florida's highly praised Covid-19 tracking dashboard came to national attention in December after the police raided her home, guns drawn ... \[Jones\] is the latest technologist who stepped up to fill the vacuum left by governments during Covid-19.” Helen A. S. Popkin, *Forbes*](#)
- [“FDLE raid dramatizes Florida's COVID-19 coverup” South Florida Sun Sentinel Editorial Board](#)
- [“Rebekah Jones Tried to Warn Us About COVID-19. Now Her Freedom Is on the Line.” Emily Bloch, *Cosmopolitan*](#)
- [“Was raid on COVID data analyst intended to send a message to Florida whistle-blowers?” Mary Ellen Klas, *Miami Herald*](#)
- [“Florida COVID-19 whistleblower: ‘Nothing’ Gov. Ron DeSantis has done with the virus has been honest.” Joy Reid, MSNBC](#)

THE FACTS: *National Review* reported, “The national attention that Jones has received is the result of her insisting that, having learned about her ‘whistleblowing,’ Governor DeSantis used his ‘Gestapo’ and ‘raided’ her house, putting her children in danger. But this, too, is a ridiculous lie... Police did indeed execute a search warrant on Jones. But they did so because a data breach at the FDOH — in which the personal information of 19,000 employees was stolen — was traced back to the IPv6 address that Comcast had assigned to Jones’s house. Governor DeSantis had nothing to do with it.”

Bodycam video of Florida Department of Law Enforcement (FDLE) agents proves that they patiently waited on Jones for just under 23 minutes, after repeated calls and knocks, until she opened her front door to a non-confrontational encounter. The video “does not appear to show police pointing their guns at anyone in the house.” See the full FDLE release [here](#).

Ultimately, the *National Review* report concluded that Governor DeSantis and FDOH leadership have been right all along: “There are no ‘whistleblowers’ anywhere in this story. There is no scandal. There is no grand fight for truth or justice.” There is only a corporate media narrative that elevates disinformation at the expense of the truth. That narrative has imploded.

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Comments are closed.

Important Update
on COVID-19 cases in Florida

Reemployment Assistance
FOR THOSE AFFECTED BY COVID-19

FOR IMPORTANT UPDATES AND INFORMATION
ON COVID-19 IN FLORIDA
Text FLCOVID19 to 888-777

SAVING THE LIVES OF MOMS AND BABIES:

ADDRESSING RACISM AND
SOCIOECONOMIC INFLUENCERS

AUTHORS

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The United States has the worst maternal health outcomes among high-income nations – despite spending \$111 billion¹ yearly on maternal and infant care. People of color, particularly Black and Indigenous birthing people¹ and parents, bear the brunt of this fundamental failing. Today, there is more recognition than ever of the influence of structural forces on maternal and infant health and a heightened willingness to address those factors in a meaningful way. We cannot afford to waste this opportunity.

Reproductive justice leaders, community-based organizations, advocates, and decisionmakers have been working together to respond to the mounting public demand for concrete solutions to address the Black maternal health crisis – even before the multiple crises of the COVID-19 pandemic, a crumbling economy, and the escalation of ongoing racial violence. Now, as decisionmakers work to rebuild a better healthcare system, a better economy, and a better nation, the needs of Black, Indigenous, and other mothers and babies of color must be placed front and center.

While there is an unprecedented interest in combating the maternal health crisis, key strategies remain largely overlooked, including addressing structurally based inequities in unmet social needs, and working to dismantle the racism and misogyny that drives them. Yes, we must continue the work of ensuring that maternity care is truly equitable, accessible, respectful, safe, effective, and affordable, but this can only take us so far. Attaining optimal and equitable outcomes that all birthing people and babies deserve – and that our nation's shared prosperity demands – our strategies must include addressing these fundamental structural drivers that undermine our health.

This series was created to provide decisionmakers with a better understanding of how different socioeconomic needs, which are driven by racism and other structural inequities, affect the health of pregnant people and their infants, and to provide concrete recommendations about how to address these needs. We must use this historic moment to advance the comprehensive policies needed so we can all thrive.

¹ We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this series prioritizes the use of non-gendered language where possible.

THE COVID-19 PANDEMIC HIGHLIGHTS HOW RACISM AND OTHER STRUCTURAL INEQUITIES SHAPE THE SOCIAL INFLUENCERS OF HEALTH

The ongoing COVID-19 pandemic's devastating effects on communities of color and people with low incomes have surfaced for the general public the harsh truths that these communities have known for generations: that their opportunities to be healthy and thrive are severely constrained by socioeconomic structural factors beyond their control that are deeply rooted in racism. Black, Indigenous, Latinx,^{††} Asian American, and Pacific Islanders have all suffered disproportionately from infection, hospitalization, and/or death due to COVID-19.² In addition, anti-Black and anti-Asian sentiments have fueled increased harassment and violence against these communities since the public health crisis began in March 2020.³

There is nothing inherently different about communities of color that explain these devastating outcomes. Rather, these inequities are the foreseeable consequences of historic and ongoing structural racism that have fed the social and economic factors that increase their risk of illness and death.

For example, people of color are more likely to be essential workers and have jobs that are not amenable to working from home, heightening their exposure to the virus.⁴ At the same time, they are least likely to have access to paid leave or health insurance, making it harder to manage their health and to self-quarantine if required.⁵ Communities of color are also the hardest hit by the pandemic's unemployment crisis,⁶ which exacerbates their disproportionately high poverty rates.⁷ On top of that, the diminishing affordable housing market and increased income inequalities have worsened housing instability in communities of color.⁸ This has, in turn, increased the risk of homelessness, making it extremely difficult to adhere to stay-at-home orders. Structures of disadvantage rooted in racism and misogyny underlie all of these factors.

These structural inequities can have an outsize impact on pregnant and birthing people. Pregnancy and childbirth can be extremely challenging, both physically and emotionally, even in the best of times. It is even more so for Black, Indigenous, and other people of color, who face an extraordinarily high risk of complications and death. The global pandemic has exacerbated these

THE PANDEMIC HAS HIGHLIGHTED, IN SHARP RELIEF, THE BREADTH AND DEPTH OF THE STRUCTURAL INEQUITIES THAT CONSTRAIN OPPORTUNITIES AND INTENSIFY RISKS FOR BLACK, INDIGENOUS, LATINX, ASIAN AMERICAN, AND PACIFIC ISLANDERS, AT AN UNCONSCIONABLE COST OF POORER HEALTH AND SHORTER LIVES.

^{††} To be more inclusive of diverse gender identities this bulletin uses "Latinx" to describe people who trace their roots to Latin America, except where the research uses "Latino/a" or "Hispanic," to ensure fidelity to the data.

challenges and risks. Stay-at-home orders and the need for social distancing have increased isolation at a time when many pregnant people feel especially vulnerable and need social support. Fear of contracting COVID, especially at a hospital during labor and delivery, adds another level of concern, especially for birthing people of color who face the dual risk of worse outcomes for pregnancy and COVID. New infection control policies in medical offices and hospitals have further isolated birthing people. In some cases, people were left to give birth without any trusted person by their side to support them.⁹ Not having a trustworthy, emotionally supportive advocate during labor and delivery (whether a loved one or a doula) increases stress and anxiety during what is often an already nerve-racking experience, which in turn elevates the risk of complications for both mom and baby.¹⁰

The pandemic has highlighted, in sharp relief, the breadth and depth of the structural inequities that constrain opportunities and intensify risks for Black, Indigenous, Latinx, Asian American, and Pacific Islanders, at an unconscionable cost of poorer health and shorter lives.

CRAFTING SOLUTIONS TO THE MATERNAL HEALTH CRISIS REQUIRES UNDERSTANDING THE DRIVERS OF HEALTH INEQUITIES

The maternity care system fails all pregnant and birthing people in the United States – but some more than others. This is why solutions to the maternal and infant health crisis must be rooted in a robust understanding of the multiple, intersecting structural and social factors that drive these avoidable inequities and unnecessary and unconscionable suffering and death – including racism. It is imperative that we use frameworks that are holistic, intersectional, and just.

Our political, economic, justice, and cultural systems create systems of oppression based on racism, misogyny, xenophobia, and classism that directly impact maternal and infant health. Racist policies have perpetuated structural forces that created and sustain inequitable systems of housing, food stability, education, health care, and safety. These and other factors are determinants of health associated with poor maternal health outcomes that birthing people of color experience.

Black and Indigenous pregnant and birthing people are particularly vulnerable because of a combination of factors spanning health care access and quality and broader structural inequities that produce adverse social determinants of health. Concretely, they are more likely to live in maternity care deserts¹¹ and have difficulty accessing comprehensive reproductive health care services,¹² while experiencing racist discrimination in the health care system.¹³ The interplay of racist discrimination in the health care system and the structural racism and discrimination faced by people of color in the United States more broadly has manifested in not only poorer birth outcomes, but also an increasing sense of mistrust of the medicalized health care community.

There is a long and painful history of eugenics and systemic manipulation in Black, brown, and Indigenous communities as well as continued mistreatment.¹⁴ Distinctively, maternal morbidity and mortality rates in the United States highlight how systematic racism harms Black women. Protecting Indigenous infants and birthing people is especially challenging because of a lack of consistent, disaggregated data.¹¹¹ In addition, the Indian Health Service, which holds the United States' treaty responsibilities to provide for the health of American Indian and Alaska Native people,¹⁵ is chronically underfunded and often cannot provide needed services.¹⁶

Effective solutions will require approaches that understand and embrace the complexity of these inequities and their root causes. The analysis, development, implementation, and evaluation of new policies must be grounded in reproductive justice, which values the collective power of community-based leaders and community-centered policy and programmatic solutions. Using systems-level analysis will allow for a more robust understanding of the interlocking systems of oppression by examining the ramifications of historic and contemporary inequitable public policies and how they produce disparate maternal and infant health outcomes. Employing an intersectional approach creates a framework to factor in more than one axis of lived experience including race, class, gender identity, geographic location, sexual orientation and other status characteristics into diagnosing the multiple barriers people face and crafting more effective, tailored solutions. Only by approaching this work holistically will we be able to begin addressing the historical systems of oppression that have undermined maternal health both within the traditional health care system and beyond it.

IT'S TIME FOR IMMEDIATE SOLUTIONS TO ADDRESS SOCIAL AND ECONOMIC DRIVERS IMPACTING MATERNAL AND INFANT HEALTH

The pandemic has shown the country that people of color are the backbone of our economy and drive our prosperity. As we work together to rebuild our health care systems, our communities, and our broader economy, we cannot simply return to a "normal" composed of structures and policies that disadvantage communities of color. On the contrary, we need new policies and structures to dismantle inequities and affirmatively strengthen the factors that contribute to the health and well-being of mothers and infants, especially those from Black, Indigenous, and other communities of color.

This series identifies concrete ways to improve maternal and infant health by addressing 10 closely interrelated factors that directly influence the health of pregnant and parenting people and their infants. We identified these topics based on their urgency, the strength of the evidence

¹¹¹ The lack of reliable and disaggregated data for Latinx and Asian American and Pacific Islander populations obscures maternal mortality and morbidity challenges some of their distinct communities face, such as Puerto Ricans and various groups of Asian Americans and Pacific Islanders.

linking structural and social influencers with maternal and infant health, and their disproportionate impact on Black, Indigenous, and other people of color. We began with available and up-to-date systematic reviews of the effects of specific social factors on maternal and infant health, but did not limit ourselves to these studies. Some of the most important factors did not have systematic reviews available, due to the biases still prevalent in scientific research. Moreover, we had to supplement systematic reviews with other reliable sources as a result of the persistent lack of racially and ethnically disaggregated data.

Women and families are being harmed by the policy decisions driving **climate change**, unhealthy **built environments**, and racist and xenophobic **immigration** policies. Lack of **paid leave** and **housing instability** are emblematic of economic structures that drive inequality. These and other social influencers of health interact to undermine **mental health**, fuel **substance use disorders**, and exacerbate the prevalence and harm of **intimate partner violence**. The over-policing and mass **incarceration** of communities of color are a direct result of many interacting social and economic factors rooted in structural racism. And no analysis would be complete without recognizing and understanding the physiological impacts of the toxic stress of **racism** that make being a person of color in the United States literally hazardous to one's health.

Though the chosen influencers may be topics with the most robust evidence, these are only a few of the many social, political, and economic factors that make it difficult for birthing people of color to thrive in our country.

THE OPPORTUNITY: WE CAN ACHIEVE EQUITABLE, OPTIMAL MATERNAL AND INFANT HEALTH

Inequities in maternal health outcomes are a manifestation of racism in our society. The ongoing maternal health crisis, which disproportionately affects Black, brown and Indigenous people, can be solved given the right tools, resources, and support. Decisionmakers must commit to improving maternal and infant health outcomes by addressing the structural and social determinants of health within a reproductive justice framework. The country is currently ripe with the opportunity to undergo a structural overhaul of the maternity care system and fix the entrenched racial, ethnic, and gender inequities that drive the crisis. Now is the moment to correct past and ongoing wrongs and to catch up to the higher standards set by our global counterparts to better achieve birth equity.

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Social Determinants of Health and Medicare Advantage:

Policy Recommendations to Achieve Greater Impact on Reducing Disparities & Advancing Health Equity for America's Medicare Population



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Medicare beneficiaries enrolled in Medicare Parts A and B may choose to receive their Medicare benefits through a Medicare Advantage (MA) plan. MA plans must cover the benefits that fee-for-service Medicare (FFS) covers and may offer additional benefits beyond traditional Medicare coverage.

Medicare Advantage serves more than 26 million seniors and individuals with disabilities, many of whom face more socioeconomic risk factors and are more financially vulnerable compared to the traditional FFS Medicare population.ⁱ Social risk factors or “social determinants of health” reflect the socioeconomic conditions in which we live, learn, work, play, and age and can include inadequate access to nutritious food, lack of affordable housing, lack of convenient and efficient transportation options, limited opportunities for quality education and meaningful employment, limited broadband access, and more. Socioeconomic barriers can impact a person’s ability to live a healthy life, access quality health care, and put them at greater risk of developing chronic conditions-leading to poorer health outcomes, more hospital admissions, and higher costs. For example, an individual may have diabetes-related hospital admissions due to food insecurity, develop asthma due to poor housing conditions, frequently visit an emergency department because of homelessness, or develop mental health conditions due to social isolation and loneliness.

There is a growing body of evidence that indicates that socioeconomic challenges not only lead to poorer health outcomes and higher healthcare costs, but they can also exacerbate health disparities for a broad range of populations as well, particularly for seniors, racial and ethnic minorities, and individuals with disabilities.ⁱⁱ The COVID-19 crisis has further exposed the health disparities and inequities that exist in America and demonstrated the crucial link between socioeconomic circumstances and health outcomes. It has also highlighted the important role policy flexibilities play in the ability of MA plans and other stakeholders to address the socioeconomic risk factors of their beneficiaries. These flexibilities facilitate more appropriate services that help address the needs of individuals, promote greater health equity, and lower total costs of care by reducing unnecessary hospital admissions and routine emergency department visits.

Addressing Socioeconomic Needs through MA Supplemental Benefits

MA plans have flexibility to offer expanded access to telehealth and supplemental benefits that go beyond Medicare FFS and can address socioeconomic barriers to health. Examples of supplemental MA benefits include: in-home support services, transportation to and from health care appointments, transportation for non-medical needs, and home delivery of essential supplies, including prescription drugs and groceries. MA plans may also offer services to eligible enrollees that address social needs, such as club memberships, family counseling, or other programs to address social isolation.

MA supplemental benefits have expanded in recent years, due in part to the introduction of special supplemental benefits for the chronically ill (SSBCI). This has enabled MA plans to offer additional supplemental benefits and supportive services to those with chronic illnesses and to manage their care more holistically. The number of MA plans offering SSBCI has rapidly increased, with triple the number of plans (787 plans) offering at least one SSBCI in 2021 compared to 239 plans offering at least one SSBCI in 2020. Similarly, the number of MA beneficiaries enrolled in plans providing SSBCI has also tripled, from 1 million in 2020 to over 3 million in 2021. The most commonly offered SSBCI benefits are meals and food and produce.ⁱⁱⁱ



Examples of MA Plan & Community Partnership Efforts to Address Social Determinants of Health

MA plans provide services directly and also work with community partners to address a variety of needs, ranging from food insecurity, lack of transportation, social isolation, housing instability and homelessness, among others. Research has demonstrated that many services and interventions that address the health-related social needs of MA beneficiaries result in improved quality of life, improved health outcomes, and significant savings by reducing unnecessary health care utilization. For example:



A Northeast MA plan became a leader in its state and a national example for vaccinating homebound populations who otherwise were not able to leave their homes to get the COVID-19 vaccine. The MA plan identifies and reaches out to those who meet the homebound criteria and handles scheduling and administration of the in-home COVID-19 vaccinations. The MA plan also manages geographic vaccination hubs that receive COVID-19 vaccines from the State and schedules qualified vaccinators (such as EMS or home health agency staff) to pick up COVID-19 vaccines and “go bags” with PPE and their list of appointments and then go out and administer the vaccines. The MA plan has not only vaccinated thousands of its own MA members who are homebound but has expanded its efforts to vaccinate over 20,000 homebound residents across the state—even those who are not members of their MA plan—to ensure people can receive the COVID-19 vaccine in the safest ways possible regardless of their circumstances. Because the MA plan’s approach to care is rooted in the community to ensure the most appropriate site of care, it has generated effective outreach and distribution strategies that have now become best practices for bringing COVID vaccinations to homebound populations nationwide, reducing disparities in access and outcomes across populations in need.^{iv}



Recognizing that social isolation is a significant issue for aging adults and can have a major impact on overall health, MA plans in both the South and the Western U.S. implemented programs that connected members who self-identified as lonely with social workers and volunteer phone pals who regularly called or visited to build relationships. The phone pals helped address the member’s needs, whether assisting with transportation, accomplishing house chores, providing companionship, or providing other services—often alleviating the burden and stress on family caregivers while enriching the lives and combatting feelings of loneliness of older adults. After implementing this program, the Western MA plan saw an increase in member engagement with other programs (e.g., exercise programs) by 56%, a decrease in hospital admissions by 21%, and a decrease in emergency department use by over 3% (while the control group saw an increase in ED use by 20%).^v



A MA plan based in the West launched a technology support program for its members to help build their digital literacy and take advantage of telehealth visits and the digital world. The service provides 1:1 technical assistance over the phone to members to help them set up email accounts, learn how to use telehealth platforms, set-up mail-order prescription delivery, learn how to navigate video conferencing platforms such as Zoom or Facetime, access various medical group and patient portals, and more.^{vi}



A MA plan in the Mid-Atlantic partnered with local housing contractors to launch a program that integrates permanent supportive housing, an assigned medical home, and case management services to coordinate health care for dually eligible Medicare and Medicaid members who are homeless, have a medical disability, and have at least one year of high health care costs. By receiving appropriate medical and behavioral health services, peer support, and case management in addition to stable housing, individuals housed through this program had less unplanned care but more visits to primary care and specialists and greater medication adherence. This has led to declining medical costs. After housing was attained, medical cost savings averaged \$8,472 per housed member per year and pharmacy costs increased \$2,088 per housed member per year (an indication of greater medication adherence), resulting in an overall annual cost savings of \$6,384 for each housed member per year.



A MA plan provided free memberships to grocery delivery services to over 200,000 of their members across dozens of states to help them safely and conveniently access groceries and everyday essentials, protect their well-being, and ensure access to the supplies they need, especially during the COVID-19 crisis.^{vii}



A health plan in the Northeast that provided weekly delivery of ten ready-to eat meals to dually-eligible Medicare and Medicaid members saw savings of \$753 per member per month (or 16% less in costs) due to fewer inpatient admissions and fewer nursing facility admissions.^{xviii}



A MA plan based in the South launched a social determinants of health value-based program that reimburses health systems when health care providers screen MA members for socioeconomic needs, document the assessment, and refer the member to appropriate resources or social services in the community (such as food banks or affordable housing) or at the health plan (such as home food delivery services).^{ix} The health plan hopes this program will incentivize providers to focus on social risk factors that contribute to poorer health conditions while providing helpful information to guide strategic decisions on how to address socioeconomic needs in the future.

Policy Recommendations to Advance MA Plans' Work that Addresses Socioeconomic Needs

MA plans have utilized policy levers and flexibilities to mitigate the socioeconomic risk factors their members face. They respond to health-related social needs in a variety of ways, ranging from offering supplemental benefits to designing and implementing new programs. Another approach involves investing their own funds in infrastructure and other innovative approaches that MA plans believe are critical to improving health outcomes but are not covered under Medicare services or waivers.

Policy Recommendations

MA plans and their community partners have made good progress in addressing health-related social needs. To achieve even greater and more lasting impact on reducing disparities and advancing health equity, the following policy recommendations would help scale and sustain MA plans' current work and facilitate additional work that address the social risk factors Medicare beneficiaries face:

- **Allow MA plans even greater flexibility to offer supplemental benefits that address socioeconomic barriers** (including for enrollees with chronic illnesses) to help prevent and mitigate worsening health conditions. For example, flexibilities should be extended to Part D benefits.
- Engage with policymakers, health plans, and other key stakeholders on **developing recommendations on health equity measures for MA Star Ratings** and other federal quality programs that are most appropriate and meaningful. Quality measurement should be fair, effective in advancing health equity or reducing healthcare disparities, and within health plan and provider control. Measures considered should be evidence-based, fully developed, tested, and accepted.
- **Develop and commit to sustaining CMS Innovation Center models that provide opportunities for MA plans and community partnerships to address social determinants of health**, particularly in rural and underserved areas.
- **Allow MA providers to participate in pooled funding arrangements with others in the community**, such as social service agencies, to more easily bring different funding sources together to have a greater impact on social determinants of health.

Conclusion

Medicare Advantage plans have a unique and growing opportunity to address the needs of socioeconomically vulnerable populations and improve their health. With the appropriate policy flexibilities that allow for broad use of social support services, **MA is well positioned to address health disparities and the underlying root causes of poor health** for the over 26 million seniors and individuals with disabilities across the country who have enrolled in the program.

Links to Additional Information And Health Plans Examples Addressing Social Determinants Of Health:

- [The Impact of Social Determinants on Health Equity and Their Root Causes](#)
- [How Health Insurance Providers Are Innovating to Address Socioeconomic Needs During COVID](#)
- [Social Determinants of Health and Medicaid Policy Priorities](#)
- [The Value of Medicaid Managed Care for Advancing Health Equity](#)
- [Bridging the Digital Divide: How Health Insurance Providers Are Addressing SDOH and Promoting Access to Telehealth](#)
- [How Health Insurance Providers Combat Social Isolation and Loneliness](#)
- [How Health Insurance Providers Provide Safe and Affordable Housing](#)
- [How Health Insurance Providers Secure Access to Healthy Foods](#)
- [How Health Insurance Providers Address the Social Determinants of Health](#)

i <https://bettermedicarealliance.org/publication/data-brief-social-risk-factors-are-high-among-low-income-medicare-beneficiaries-enrolled-in-medicare-advantage/>

ii <https://pubmed.ncbi.nlm.nih.gov/32975173/>; <https://pubmed.ncbi.nlm.nih.gov/32748673/>; <https://ajphaphapublications.org/doi/abs/10.2105/AJPH.2013.301421>; <https://pubmed.ncbi.nlm.nih.gov/29358482/>; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2806885/>

iii <https://avolere.com/insights/ma-enrollment-in-plans-with-extra-benefits-for-chronically-ill-tripled-in-2021>

iv <https://www.commonwealthcarealliance.org/news/2021/march/commonwealth-care-alliance-to-lead-massachusetts-h>

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vii <https://www.ahip.org/wellcare-tackles-social-needs-for-medicare-members-during-covid-19-pandemic/>

viii <https://pubmed.ncbi.nlm.nih.gov/3009050/#affiliation-1>; <https://pubmed.ncbi.nlm.nih.gov/30421335/>; <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0999>

ix <https://www.modernhealthcare.com/payment/humana-launches-medicare-advantage-pay-program-social-determinants>



Written Statement of J. Nadine Gracia, MD, MSCE
 President & Chief Executive Officer
 Trust for America's Health

**House Committee on Energy & Commerce, Subcommittee on Health Hearing:
 "Empowered by Data: Legislation to Advance Equity and Public Health"**

June 24, 2021

My name is Nadine Gracia, and I am the President and CEO of Trust for America's Health (TFAH). TFAH is a nonprofit, nonpartisan public health policy, research, and advocacy organization which, promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. At TFAH, we envision a nation that values the health and well-being of all and where prevention and health equity are foundational to policymaking at all levels. I am pleased to submit this testimony to the Subcommittee as you consider important public health issues, including the social determinants of health (SDOH), public health data and equity, as we have long highlighted the importance of addressing social determinants of health as a critical component of public health and prevention. In particular, I would like to express our strong support for the Improving Social Determinants of Health Act (H.R. 379).

COVID-19, Health Outcomes, and SDOH

The pandemic has highlighted in all-too tragic terms that the circumstances of one's environment have an outsized impact on a person's health risks and outcomes. Some social determinants of health put people at higher risk for contracting COVID-19, such as unsafe or unstable housing, lack of transportation, and being employed in frontline settings. Social determinants also may put people at higher risk for poor health outcomes if they do contract the virus. For example, residential redlining has led to intergenerational, concentrated poverty, and environmental health risks and is tied to higher rates of asthma,¹ obesity,² and higher mortality rates from chronic disease.³ In turn, these are also risk factors for hospitalization and death due to COVID-19. The pandemic is also worsening health disparities tied to social determinants, as job losses and

¹ Nardone, A et al. Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study. *The Lancet Planetary Health*, Vol. 4, Issue 1, E24-E31, Jan 1, 2020.

² Bower, Kelly M et al. "Racial Residential Segregation and Disparities in Obesity among Women." *Journal of Urban Health: Bulletin of the New York Academy of Medicine* vol. 92,5 (2015): 843- 52.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608933/>

³ Goodman MS and KL Gilbert. "Segregation: Divided Cities Lead to Differences In Health." Washington University in St. Louis and Saint Louis University. Nov. 2013.

economic stress have led to increased rates of obesity,⁴ food insecurity,⁵ and behavioral health concerns such as depression and anxiety,⁶ particularly in some populations of color. TFAH has an ongoing initiative called Promoting Health and Cost Control in States, where we examined over 1,500 state-level policies, programs, and strategies, focusing on those that had both a positive health and economic impact. What we found is that many of the strategies with the most promising outcomes were about social determinants, such as housing, income, nutrition, built environment, and education.⁷

The pandemic is not the only example of SDOH impacting health in a meaningful way. Even health outcomes influenced by behavior – such as poor nutrition – have roots in social determinants. For example, people living in U.S. counties with the most poverty are also most prone to obesity.⁸ Historically under-resourced neighborhoods and racially segregated neighborhoods tend to have a greater number of features that promote obesity and fewer resources that support health and wellness.^{9,10} There are multiple reasons – including lack of grocery stores, lack of access to nutritious foods, higher levels of stress, and less access to safe spaces for physical activity. Stable and safe housing is a key social determinant of physical and mental health, with unstable or substandard housing leading to lead exposure, asthma, cardiovascular events, psychological distress, and other health risks.¹¹ Policymakers cannot hope to address health costs without addressing the social and economic drivers of poor health.

Social Needs vs. Social Determinants

I also want to make a distinction between a patient's individual social needs and social determinants of health. Social needs focus on the individual or family's unmet nonmedical needs, while social determinants focus on community or environmental conditions that contribute to health outcomes. In fact, while access to medical care is important, most of a person's health is not determined in the doctor's office, or even in their genetic code, but instead

⁴ Brian P. Jenssen, Mary Kate Kelly, Maura Powell, Zoe Bouchelle, Stephanie L. Mayne and Alexander G. Fiks COVID-19 and Changes in Child Obesity. *Pediatrics* May 2021, 147 (5) e2021050123; DOI: <https://doi.org/10.1542/peds.2021-050123>

⁵ [Food Insecurity and Poverty in the US - Feeding America](#) March 2021.

⁶ K Orgera et al. Implications of COVID-19 for Social Determinants of Health. Kaiser Family Foundation, June 9, 2021. <https://www.kff.org/coronavirus-covid-19/issue-brief/implications-of-covid-19-for-social-determinants-of-health/>

⁷ Promoting Health and Cost Control in States (PHACCS). Trust for America's Health. <https://www.tfah.org/initiatives/promoting-health-cost-control-states-phaccs/>

⁸ [Poverty and Obesity in the U.S. | Diabetes \(diabetesjournals.org\)](#)

⁹ Fraser LK Edwards KL, Cade J, and Clarke GP. "The Geography of Fast Food Outlets: A Review" *International Journal of Environmental Research and Public Health*, 7(5): 2290-2308, May 2010. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2898050/> (accessed July 23, 2020).

¹⁰ Kwate NOA. "Fried chicken and Fresh Apples: Racial Segregation as a Fundamental Cause of Fast Food Density in Black Neighborhoods." *Health Place*, 14(1): 32-44, 2008. <https://pubmed.ncbi.nlm.nih.gov/17576089/> (accessed July 23, 2020).

¹¹ "Housing And Health: An Overview Of The Literature, " Health Affairs Health Policy Brief, June 7, 2018.DOI: 10.1377/hpb20180313.396577.

is based on the conditions in which the person is born, lives, works, and plays.¹² The healthcare system is recognizing that they cannot effectively treat patients if they do not address the patient's individual social needs first. In January 2021, the Centers for Medicare & Medicaid Services (CMS) announced guidance for states to use different approaches and reimbursement methodologies in Medicaid and CHIP programs to address unmet beneficiary social needs, such as housing, nutrition, and transportation.¹³ CMS' Accountable Health Communities Model also seeks to focus on the gap between clinical care and community services by identifying and addressing health-related social needs of Medicare and Medicaid beneficiaries.¹⁴ These are important developments. For example, a hospital may screen for a patient's social needs, such as asking them questions about housing and food access. Increasingly, we are seeing examples of healthcare systems and insurers helping certain patients access these social needs. But what if the person lives in an area where there is no available affordable housing, or public transportation, or grocery stores? These are further upstream, social determinants of health.¹⁵ We must address both social needs *and* community-level social determinants if we hope to avert healthcare costs, address health inequities, and promote community resilience for future health emergencies.

The Role of Public Health in Addressing SDOH

It is the fundamental work of public health to prevent disease. Yet, just as a doctor may be frustrated that they can treat a patient's diabetes but are unable to address the patient's nutritional needs, public health cannot truly prevent disease and address health disparities without addressing community social determinants. TFAH believes that addressing these social determinants requires working across sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity.¹⁶ This is the logical role of public health and envisioned in the Public Health 3.0 model, which requires public health officials to serve as chief health strategists for their communities. With appropriate support, public health can play key roles in addressing SDOH: they can offer best practices, analyze and share data across sectors, convene different governmental and community-based organizations to identify and address barriers to health, provide the evidence base for effective policies and interventions, and collaborate across sectors to prioritize and implement evidence-based strategies. Rather than working in a silo, public health can bridge the gap across sectors and meet the needs of the larger population to address underlying causes of poor health outcomes and high

¹² World Health Organization, Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

¹³ CMS. CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies. Jan 7, 2021. <https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs>

¹⁴ CMS. Accountable Health Communities Model. <https://innovation.cms.gov/innovation-models/ahcm>

¹⁵ Castrucci BC and J Auerbach. Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health," *Health Affairs Blog*, January 16, 2019. DOI: 10.1377/hblog20190115.234942 <https://www.healthaffairs.org/doi/10.1377/hblog20190115.234942/full/>

¹⁶ DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. *Prev Chronic Dis* 2017;14:170017. <http://dx.doi.org/10.5888/pcd14.170017>

healthcare costs. We are seeing examples of these multisector coalitions in many communities, yet we do not fund public health to lead and participate in these partnerships.

Social determinants are increasingly integral to the success of public health. SDOH are featured throughout the U.S. Department of Health and Human Services' (HHS) Healthy People 2030 framework, as HHS acknowledges that economic stability, social and community context, neighborhood and other factors are closely linked with the department's objectives for the nation.¹⁷ However, CDC, and public health in general, are largely funded disease by disease. So, while unstable or unsafe housing may be a common driver across health conditions such as HIV, substance misuse, obesity, and asthma, public health agencies across the country receive siloed funding to address each of these health issues in isolation from each other and from the common social determinant. Most local and state health and community agencies lack funding, personnel, and tools to support cross-sector efforts. Given appropriate funding and technical assistance, more communities could engage in opportunities to address social determinants of health that contribute to high healthcare costs and preventable inequities in health outcomes.

Improving Social Determinants of Health Act

For these reasons, TFAH is strongly supportive of legislation sponsored by Representative Nanette Barragán, the *Improving Social Determinants of Health Act* (H.R. 379). We are joined by over 450 national, state, and local organizations in endorsing this bill.¹⁸ This legislation would authorize a program at the Centers for Disease Control and Prevention to lead the agency's SDOH work and award grants to state, local, territorial, and Tribal health agencies and organizations to address SDOHs. The bill would improve health outcomes and reduce health inequities by coordinating CDC's SDOH activities across the agency and building the capacity of public health to address SDOH in ways that I have described. In essence, the legislation is saying that SDOH should be core components of a 21st century public health system.

A key component of Representative Barragán's legislation is the support of multisector partnerships across the country. The legislation is needed to help create the infrastructure and guidance for a state and local grant program. The bill would also require an independent evaluation of grants and report the findings to Congress. We are grateful for the leadership of Representative Barragán and her staff on this critical issue.

Funding to Address SDOH

It is also important to note that effective implementation will not be possible without funding. We are therefore also supportive of the President's FY2022 budget request for \$153 million for CDC's SDOH program. More than 200 groups signed a recent letter to appropriators in support of this funding level.¹⁹

¹⁷ [Social Determinants of Health - Healthy People 2030 | health.gov](https://www.health.gov/healthy-people-2030) HHS.

¹⁸ The Improving Social Determinants of Health Act of 2021 Background. April 2021. <https://www.tfah.org/wp-content/uploads/2020/08/SDOH-bill-fact-sheet.pdf>

¹⁹ Sign-on Letter Supporting CDC's Social Determinants of Health Funding. April 2021. https://www.tfah.org/wp-content/uploads/2021/04/CDC_SDOHFunding_SignOn.pdf

CDC is currently preparing to expand its footprint to ensure, if it does receive additional funding, it is ready to hit the ground running. CDC supported a pilot project, Strengthening Public Health Systems and Services Through National Partnerships, to assess multisector partnerships in 42 communities across the country. This pilot is allowing CDC to build the evidence base for the types of collaborative approaches authorized in H.R.379, assess the impact, and highlight successful strategies. We are grateful that Congress also provided \$3 million to CDC in the FY 2021 appropriations bill for jurisdictions to develop “SDOH accelerator plans to improve health and resilience among populations adversely affected by characteristics of the built environment, food security, clinical-community linkages, social connectedness, and other SDOH domains.”²⁰

The President’s FY2022 request would enable CDC to expand on these planning activities to address SDOH in all states and territories, including initiating an SDOH implementation program and continuing to build the evidence base. In addition to meeting the President’s Request for FY2022, we feel the authorization is important to further flesh out the program and create the structure and guidance to the agency for SDOH implementation grants. Although this work is housed in the CDC’s National Center for Chronic Disease Prevention and Health Promotion, the work has benefits across the public health spectrum. As we have seen in the pandemic, health disparities, the prevalence of chronic health conditions, and risk during a public health emergency are inextricably linked.

Conclusion

Although I have focused my statement on one bill, we appreciate that the Committee is examining a range of strategies to addressing social determinants and promoting health equity. We have endorsed other bills being considered today, including the Social Determinants Accelerator Act and the Black Maternal Health Momnibus, which includes the Data to Save Moms Act and the Social Determinants for Moms Act. These are complex issues, and it will take an all-of-government approach to address the social and economic factors that have such a significant impact on health outcomes. We look forward to working with the Committee to advance H.R. 379.

²⁰ [Fiscal Year 2022 Centers for Disease Control and Prevention \(CDC\) Congressional Justification](#)



Ending sickle cell disease is a matter of racial justice

BY BRETT P. GIBBOIR, OPINION CONTRIBUTOR — 06/15/21 11:31 AM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

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One hundred thousand Americans — the great majority of whom are Black — have sickle cell disease, an excruciatingly painful, terminal disease that on average leads to death before age 50, but for many much younger. But my review of Symphony Health Claims Data revealed only 30 percent of these one hundred thousand receive any form of medical treatment despite its widespread availability. Can you imagine the outcry if only 30 percent of Americans with cancer received treatment?

But at least we now clearly understand our national deficiencies. As reported by the Center for Medicare and Medicaid Service (CMS) for the nearly 42,000 people with sickle cell disease insured by Medicaid, only 16 percent of children and 10 percent of adults receive hydroxyurea, a daily pill that can reduce pain, prevent hospitalizations, improve function and save lives. Even more shocking, only one third of children receive a simple annual recommended ultrasound screening to determine their risk of strokes and help prevent them from occurring. And despite the FDA approval in 2019 of two new breakthrough therapies, access to these therapies is already being thwarted by a quagmire of medical indifference, bureaucracy and artificial barriers not supported by science.

Sickle cell disease is caused by a genetic mutation in one out of three billion DNA bases, no fault of its victims. This mutation arose 7,300 years ago, in a single child living in the Sahara region. One copy of this gene conferred resistance to malaria, a major killer in tropical areas; and thus, the mutation flourished, today present in 8 to 10 percent of African

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[Americans](#), and an estimated 100 million people around the world. But when two individuals who carry a single copy of the mutation have children, on average one-in-four of their children have two copies of the mutation and thus sickle cell disease.

Now, because of advances in diagnostics combined with smart policies, all babies in the U.S. are now [screened for sickle cell disease at birth](#), identified and given life-saving care by pediatric specialists. This has resulted in [dramatic improvements](#) in lifespan from the teens to mid-40s, with concomitant improvements in quality of life. However, most individuals with sickle cell disease still face overwhelming [obstacles to health care](#) as they become young adults, and thus their dreams of a normal life rapidly fade.

Our team at the U.S. Department of Health and Human Services (HHS) prioritized initiatives for people with sickle cell disease with the goal of normalizing their life-spans and quality of life. We created an [interagency task force](#), [educated](#) providers and patients, [enhanced awareness](#) in Congress and the White House, [improved data collection](#) at Centers for Disease Control and Prevention and CMS, increased [National Institute of Health sponsored research](#), [incentivized appropriate prescribing](#), approved two novel medical therapies and developed a [national blueprint for action](#) through the National Academies of Science, Engineering, and Medicine (NASEM). And because of both public and private research, potential curative gene therapies are [demonstrating dramatic successes](#) in early clinical trials.

But more progress is needed. HHS should publish an annual sickle cell disease report card that assesses quality of care and progress on implementing the NASEM blueprint. Congress should fully fund the CDC Sickle Cell Data Collection Program, and mandate that CMS includes quality parameters for state Medicaid programs that incentivize stroke screening, vaccines, preventive health visits and appropriate use of medical therapies. The administration should increase budgets for sickle cell disease research at NIH and for education of health care professionals through the U.S. Health Resources and Services Administration. Congress should fund new grants for community health centers to implement multi-disciplinary care for sickle cell disease, including telemedicine linkages to medical specialists. The NIH should update its 2014 sickle cell disease treatment guidelines to provide specific recommendations for use of new therapies. It is also essential to establish a fair and equitable payment system, so that when expensive genetic cures become available, everyone in need can receive them.

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Finally, in Sub-Saharan Africa, where there is neither universal newborn screening nor basic sickle cell disease care, an estimated [50 to 90 percent](#) of the 300,000 babies born with SCD annually will die before their fifth birthday. As such, the administration should support the newly formed [Global Coalition to End Sickle Cell Disease](#), which HHS established in collaboration with the World Health Organization and the World Bank. By implementing inexpensive newborn screening for basic sickle cell disease, we can save the lives of an estimated 10 million children worldwide by 2050.

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Ending sickle cell disease is a matter of racial justice | TheHill

There is strong evidence to support that [racism and discrimination](#) underlie the historic inequities in sickle cell disease research, funding, health policies and national attention. With health equity being the mantra of the Biden administration, it is an ideal time to implement these additional policies. There would be no stronger affirmation of our national commitment to equity and racial justice than to prioritize assistance to those suffering from this disease.

Brett P. Giroir, MD, is former assistant secretary for Health, U.S. representative to the Executive Board of the World Health Organization and former admiral, U.S. Public Health Service.

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ACHIEVING HEALTH EQUITY THROUGH CROSS-SECTOR COLLABORATION

June 23, 2021

The Honorable Anna Eshoo
Chairwoman of the Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
272 Cannon House Office Building
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member of the Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie,

On behalf of The Root Cause Coalition (TRCC), we write in support of your continuing work to better understand the impacts of economic and social conditions on health during the subcommittee's upcoming hearing "Empowered by Data: Legislation to Advance Equity and Public Health" scheduled for June 24th, 2021. This hearing is a valuable opportunity to discuss the importance of social determinants and public health data, especially in light of the disproportionate impact of the COVID-19 pandemic. Of the bills scheduled to be discussed, TRCC offers its endorsement of the following:

H.R. 379 - Improving Social Determinants of Health Act of 2021, sponsored by Rep. Nanette Barragan [D-CA]
H.R. 925 - Data to Save Moms Act, sponsored by Rep. Sharice Davids [D-KS]
H.R. 943 - Social Determinants for Moms Act, sponsored by Rep. Lucy McBath [D-GA]
H.R. 2503 - Social Determinants Accelerator Act of 2021, sponsored by Rep. Cheri Bustos [D-IL]

TRCC's advisory Council is also presently reviewing the following bills for potential endorsement in the near future:
H.R. 666 - Anti-Racism in Public Health Act of 2021, sponsored by Rep. Ayanna Pressley [D-MA]
H.R. 831 - Health STATISTICS Act of 2021, sponsored by Rep. Scott Peters [D-CA]
H.R. 3894 - CARING for Social Determinants of Health Act of 2021, sponsored by Rep. Lisa Blunt Rochester [D-DE]
H.R. 976 - ETHIC Act, sponsored by Rep. Kathy Castor [D-FL]

By way of background, TRCC is a non-profit, national organization with over 90 members representing a wide variety of sectors including health systems, hospital associations, foundations, businesses, national and community nonprofits, health insurers, academic institutions and policy centers. Our organization was established in 2015 to bring together these cross-sector partners to reverse and end the systemic root causes of health inequities by addressing the social determinants of health.

As a Coalition, we appreciate your leadership and your continued attention to health and economic inequalities. We stand ready to support your efforts towards our mutual goals of achieving health equity for every American. Sincerely,

Barbara Petee
Executive Director
The Root Cause Coalition

Thomas Dorney
Director
The Root Cause Coalition

GOOGLE'S SUBMISSION IN RESPONSE TO
SUBCOMMITTEE QUESTIONS FOR THE RECORD
FOLLOWING JUNE 24, 2021 HEARING

Written Questions Submitted by the Honorable Angie Craig (D-MN)

1. Dr. DeSalvo, you discussed your work at Charity Hospital and how you partnered with the community to create a system that addressed both ongoing health challenges and the social determinants of health. As you know, healthcare is about more than just treating illness. How can we reimagine our healthcare system to prioritize well-being and quality of life, and remove barriers to integrative care, particularly for communities faced with health disparities?

Designing healthy communities with a lens toward equity is not something the health care sector is currently able to address on its own. Improving health inequities requires shifting focus from individual patients to population-level challenges and opportunities, which would reveal disparities beyond medical care (e.g., access to healthy food, quality education, housing, and transportation). Congress should consider developing a comprehensive public health system that will not only resource federal public health entities, but also support localities who know the community best.

Currently public health capacity varies greatly across the country. As Congress takes steps to modernize the public health infrastructure, it should avoid focusing on funding a fragmented field and instead focus investment on building stronger systems to support where the field is going. The National Academy of Medicine's 2019 report "Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health" shares some key recommendations on the integration of social care into health care delivery.¹ Additionally, awareness of social risk can provide solutions and assistance by connecting patients with the appropriate resources. Alignment of the social and health care sectors allows health care systems to understand their communities' existing social care assets, enable synergies, and invest in and deploy them to positively affect health outcomes.

Of course, integrating social care into health care requires an appropriately staffed and trained workforce, including health IT innovations and new financing models. In addition to leaders in the social and health sectors, policymakers will be critical in the development of a modernized public health infrastructure that is interoperable between health care and social care organizations, as well as in the financing of social care as part of health care delivery. That system should be durable in design, sustainable in operations, and governed with appropriate accountability to the public.

¹ https://www.nap.edu/resource/25467/09252019Social_Care_key_messages.pdf

Written Questions Submitted by the Honorable Richard Hudson (R-NC)

1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.

a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?

Yes, multi-disciplinary and cross-sector collaboration is critical to driving advancements in the social determinants of health. The public and private sectors should work together to enable more real-time and geographically granular data to be shared, linked, and synthesized, while protecting data security and individual privacy. This includes developing a core set of standards that encompass health care and public health, particularly the social determinants of health, environmental outcomes, and health disparities.

For example, during the ongoing COVID-19 pandemic, health departments formed cross-sector partnerships, collaborating with academia to construct dashboards and leveraging anonymized datasets shared by the private sector. At Google, we have partnered with Ariadne Labs at Harvard to develop a [Vaccine Equity Planner](#) dashboard that helps integrate data from Google Maps API (same API that powers navigation in Google Maps; this dataset does not contain any user data) with data from the CDC (such as the CDC's [social vulnerability index](#)) and other public health organizations to identify and close disparities in COVID-19 vaccination rates. Projects like the [Google COVID-19 Search Symptom Trends](#) illustrate how public health can leverage novel data signals in a privacy-preserving manner to address the upstream drivers of health and improve emergency preparedness.

b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?

Congress should commit to creating an interoperable public health data system, which includes the use of open and non-proprietary standards and FHIR-based application programming interfaces like those expected for healthcare in 21st Century cures. Long-term investments are needed to modernize health departments' data, infrastructure and informatics capabilities. While Congress has appropriated over \$1 billion for the CDC's Data Modernization Initiative, such overdue resources are the means, not the ends. Policymakers need to learn from HITECH—the government's response to data modernization in the health care sector, which had thirtyfold more funding and still faced roadblocks—to ensure public health data can meet the needs of America's population.

While serving as the Acting Assistant Secretary for Health, we published our [Public Health 3.0](#) call to action, which provides a North Star for orienting the data modernization journey. It focuses on integrating public health data, clinical information, and metrics related to the social determinants of health. Public health services must build for the future, designing systems that are capable of integrating traditional (e.g., vital statistics, registries), expanded (e.g., health records, claims), and novel (e.g., anonymous, privacy-first web search queries) data signals.

Timely, reliable, granular-level (i.e. county), and actionable data should be made accessible to communities throughout the country, with clear metrics to help document success and progress and always with rigorous privacy controls. In order to meet the community where they are, we need to create a public health system capable of blending timely quantitative data with feedback from the public to generate actionable insights for health.

It is imperative that legislation and policy making focus on the systems that collect, exchange, and act on data rather than on the data itself. This will require a combination of infrastructure upgrades, workforce investments, and operational redesign.



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November 23, 2021

The Honorable Frank Pallone Jr
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The Honorable Cathy McMorris Rodgers
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The Honorable Anna G. Eshoo
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Washington, DC 20515

RE: SCAN Health Plan's Response to "Empowered by Data: Legislation to Advance Equity and Public Health" Questions for the Record

Thank you for the opportunity to provide additional information to the members of the Committee on Energy and Commerce. We applaud the Committee's efforts to advance health equity and welcome the opportunity to continue to be a resource. Please accept the below responses as SCAN Health Plan's formal written response to the additional questions.

The Honorable Brett Guthrie (R-KY)

1. Dr. Batra, you state in your testimony your support for the added flexibility Congress in 2019 provided to Medicare Advantage plans like yours to offer supplemental benefits to folks with chronic conditions. Additionally, CMS offered even greater flexibility to support seniors during COVID. I know Humana from my home state of Kentucky has utilized this flexibility to, among other things, connect directly with seniors and screen for conditions such as food insecurity. From there, they've taken action to directly and rapidly support seniors by working in real time with anti-hunger organizations and others to get meals directly to their members. To date, they've supported nearly 90,000 individuals with more than 1.4 million meals. I for one, believe these types of direct and targeted intervention in Medicare Advantage demonstrate how crucial supplemental benefits received by the 26 million seniors who rely upon Medicare Advantage are, and see this as an important opportunity for innovation.

a. If given additional flexibility to focus supplemental benefits for other groups such as those with low incomes, what type of improved health outcomes would you expect to see?

SCAN is grateful to Congress for allowing greater flexibility to offer supplemental benefits to people with chronic conditions. As a nonprofit MA plan with a long history of serving older adults and vulnerable populations, we know first-hand how supplemental benefits improve the lives of our members.

We respectfully ask Congress to continue allowing MA plans to offer flexible benefits and consider extending them to additional populations in the future, such as people who are experiencing homelessness. In July 2019, SCAN launched a Housing and Homelessness Care Management Initiative that focuses on collaborating with providers and community-based organizations to provide long-term complex case management to homeless or at-risk members. This program offers social supports to these members with a particular focus on getting the member housed or helping the member keep their current housing.

In addition, we recommend that Congress expand the criteria for supplemental benefits beyond specific chronic conditions to include the social determinants of health (SDOH). Expanding supplemental benefit criteria would help mitigate some social inequities and allow health plans to expand services to more members in need. Providing plans additional with this flexibility will allow plans the opportunity to improve health outcomes for more groups. A growing body of evidence demonstrates that specific SDOH interventions can improve health outcomes.¹ Additionally, these interventions can effectively improve beneficiary health while controlling medical costs, particularly for more expensive populations served by Medicare Advantage.

The Honorable Gus Bilirakis (R-FL)

1. As a staunch supporter of Medicare Advantage, I was pleased to see CMS provide much-needed flexibility to allow healthcare providers to offer telehealth services under MA plans; however, CMS's guidance requires that these services include a video component, which is not an option for some patients. Low-income and rural patients for example, may have trouble accessing technology or broadband services supporting video communications. Additionally, seniors or frail populations may have physical limitations that prevent them from using video communications. For these patients, an audio-only telehealth visit may be the only option besides delaying (or foregoing altogether) needed care.
 - a. On August 3, 2020, CMS updated their risk-adjustment telehealth policy for ACA plans to allow for reimbursement for audio-only visits for purposes of risk-adjustment; however, the same has not yet been extended to MA plans even though the same audio-only services are being provided by the same clinicians using the same coding guidance. I sincerely appreciate your support of a bipartisan bill I introduced with my colleague Congresswoman Sewell—H.R. 2166, the “Ensuring Parity in MA and PACE for Audio-Only Telehealth Act”. Are there any ongoing concerns that you are aware of with programmatic fraud that may merit differences between the two programs, or should certain guardrails be put into place if such a policy was extended to MA plans, and, if so, what should those guardrails be?

We applaud your efforts to establish parity for audio-only telehealth and support H.R. 2166, the “Ensuring Parity in MA and PACE for Audio-Only Telehealth Act.” We also commend CMS for related actions that encourage those practices, such as allowing Medicare Advantage plans to take into account diagnoses from telehealth encounters with both audio and video components for risk adjustment purposes. However, many low-income patients, seniors, or residents of rural areas have trouble accessing the technology or broadband internet service. In addition, many have

¹ University of Wisconsin Population Health Institute. “What Works for Health.” County Health Rankings & Roadmaps, 2021.

expressed difficulty in navigating the video technology included on video-equipped smartphones and similar devices.

We are aware that some people are concerned that providing payment for audio-only may result in fraud, but we have not witnessed this. We recommend that CMS engage with MA plans and providers to identify guardrails to ensure that audio-only can continue to be a tool for vulnerable populations who do not have access to broadband or appropriate technology.

b. What conclusions have private payers that have expanded telehealth drawn from their experiences over the past year regarding utilization of services, patient satisfaction, and program integrity?

During the COVID-19 pandemic, SCAN Health Plan leveraged several flexibilities to address the needs of our members. As providers paused in-person care, we leveraged telehealth flexibilities to ensure our members were able to access the care they needed. We prioritized increasing access to care by driving telehealth utilization by offering zero copays for virtual physician visits, emphasizing member education, and increasing marketing campaigns to make members aware of our telehealth offerings. We also offer HEALTHtech, a technology support line that helps members use a computer, tablet, or smartphone to access healthcare and health-related information and services. We are in the process of analyzing data on the utilization of these benefits for 2020 and 2021.

c. On August 14, 2020, CDC reported that rates of substance abuse, anxiety, severe depression, and suicidal ideation increased across many demographics. Of grave concern, the report indicated that over 1 in 4 young adults had recently contemplated suicide. Additional research revealed that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic. Overall, mental health conditions were the top telehealth diagnoses in the nation in November 2020—signifying an almost 20% increase year over year, with no indication that this trend is reversing. Can you speak to the role that telehealth flexibilities – such as the ability to serve a patient in their home and provide audio-only services, particularly for addressing mental health and substance use disorder – have provided during this time?

Improving access to mental health services is an essential step in improving care outcomes and reducing health inequities. This is especially true for the Medicare population. A July 2020 Commonwealth Fund study found that about one in four Medicare beneficiaries have a mental illness, with the prevalence of severe mental illness being the highest among dual-eligible Medicare-Medicaid beneficiaries². Studies have also shown that mental and physical conditions frequently co-occur, and comorbidity often worsens both mental and physical health outcomes.³ In addition, the COVID-19 pandemic has continued to negatively impact mental health and created new barriers for people who may have already been suffering from mental illness and substance use disorders. Therefore, it is important for policymakers to enact policies that facilitate beneficiaries' access to high-quality mental health and substance use care in addition to high-quality medical care.

² Beth McGinty, [Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement](https://doi.org/10.26099/sp60-3p16) (Commonwealth Fund, July 2020). <https://doi.org/10.26099/sp60-3p16>

³ Stephen J. Bartels and John A. Naslund, "The Underside of the Silver Tsunami — Older Adults and Mental Health Care," *New England Journal of Medicine* 368, no. 6 (Feb. 7, 2013): 493–96

SCAN appreciates the additional telehealth flexibilities put in place during the ongoing COVID-19 public health emergency, such as waiving originating site requirements for telehealth services under Medicare, as well as allowing reimbursement of more video-enabled telehealth and audio-only telehealth services. During the COVID-19 pandemic, SCAN Health Plan leveraged several flexibilities to address SDOH during the pandemic. As providers paused in-person care, we leveraged telehealth flexibilities to ensure our members were able to access the care they needed.

To use in-home audio-only services as a means to treat mental health and substance use, SCAN recommends that Congress pass the bipartisan legislation, the Ensuring Parity in MA for Audio Only-Telehealth Act (S. 150). This legislation will ensure Medicare beneficiaries continue to have access to high-value care and supplemental benefits provided by MA, as well as reduce health disparities due to unequal access to health technology and video telehealth platforms. The legislation would also ensure audio-only telehealth continues to be an effective source of health care for Medicare beneficiaries and supports the providers caring for them throughout the COVID-19 public health emergency.

The Honorable Richard Hudson (R-NC)

- 1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.**

- a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?**

SCAN agrees that investment into entities working to help advance best practices related to SDOH can drive progress in improving health equity. We agree that investment in data platforms that track medical and social conditions and facilitate access to services is essential to driving progress in improving health inequities. Therefore, we recommend that Congress advance policies that promote the interoperability of electronic systems to optimize care coordination and improve patient health outcomes. Interoperability allows for seamless and timely transfers of information, enabling patients, health plans, providers, and other members of a patient’s care team to develop comprehensive care plans. Making improvements to encourage interoperable electronic systems would remove data sharing barriers and increase the utilization and effectiveness of care coordination.

- b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?**

Improving care across the continuum of mental health and substance use health services is essential to addressing unmet needs in this area. Policymakers can achieve this by building upon existing HHS efforts to standardize data collection and reporting on race, ethnicity, language, sexual orientation, gender identity, disability, and other sociodemographic data will help ensure a

better understanding of beneficiaries' identities, which will help inform appropriate care and interventions. Data standardization will also help facilitate data aggregation, reporting, and interoperable sharing, which will help identify and address disparities.

Data collection is also essential to identifying and addressing patient needs. This is especially true for underserved populations. For example, a key component of how SCAN identifies members' health needs is through our Health Risk Assessments (HRA). All SCAN members receive a HRA, which gathers data on 1) Health Behavior and Status, 2) Demographics, and 3) Social Determinants of Health (SDOH). It includes several questions on SDOH and basic needs, such as housing, language and literacy, medical needs, food, transportation, social connectedness, and isolation. Since 2018, approximately 80,000 SCAN members have completed a HRA, with about a 35 percent response rate. For SCAN's Special Needs Plan (SNP) members, the HRA completion rate is 80 percent. After collecting members' SDOH data, we stratify the information based on clinical risk and unmet social needs. This allows us to direct people to appropriate programs that meet their individual, unique health needs across the continuum of care. Without these data, identifying and addressing member needs, and therefore improving health outcomes would be much more difficult.

Lastly, SCAN recommends that Congress advance policies that promote the interoperability of electronic systems to optimize the use of care coordination and improve patient health outcomes. Interoperability allows for seamless and timely transfers of information, enabling patients, health plans, providers, and other members of a patient's care team to develop comprehensive care plans. Making improvements to encourage the use of interoperable electronic systems would remove data sharing barriers and increase the utilization and effectiveness of care coordination.

Thank you for the opportunity to provide additional answers to members of the Energy and Commerce Committee. We look forward to working with the Committee on future efforts to advance health equity and public health.

Sincerely,



Romilla Batra, M.D., M.B.A.
Chief Medical Officer
SCAN Health Plan

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
“Empowered by Data: Legislation to Advance Equity and Public Health”
June 24, 2021

Ms. Beth Blauer, Executive Director, Johns Hopkins University Centers for Civic Impact

The Honorable Kathy Castor (D-FL)

1. Ms. Blauer, you also mention that H.R. 976 could be strengthened by requiring public health data reporting for states moving forward. What would be the benefit of requiring states to report data? Do you have any recommendations on the type of data that should be reported – especially to address equity?

There are a number of reasons why structuring state reporting of public health data could provide benefit. Here are the two most significant:

1. **Expose opportunities to reform.** The first and most essential reason why collecting public health data regularly from the states is the capacity for this data to reveal the opportunities for the public health system to cure generational flaws that have created massive inequities in access to care, solid public health information, and meeting basic public health needs. If COVID-19 is the example, we have learned that in the face of a public health emergencies, our public health system is ill-equipped and vulnerable. Significant inequalities emerged in who has access to testing, vaccination, and solid public information. These inequities contribute to disproportionate death and hospitalization in black and brown communities.
2. **Standardization of Data.** Structuring the state data would allow the federal government to provide much needed guidance to the states on how to define core demographic and programmatic categories in their data collection efforts. This alignment would make it easier for policy makers to understand what works, where there are specific needs, and how to be strategic with investments. The absence of this consistency leads to limited visibility into strategies that deliver results, creates disparities, and exacerbates some of the worst outcomes. To start these standards could focus on uniform demographic categories for:
 - a. Standard age bands
 - b. Inclusive gender categories
 - c. Ethnicity

d. Race

Having uniform demographic categories across programs will allow policy makers to have a full understanding of the impact of investment across the population.

The Honorable Richard Hudson (R-NC)

1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.

- a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?

Yes, having medical records with social data is ideal. This must be approached with care. We need to prioritize and ensure privacy and safe handling of data—which is not impossible. This requires people who know how to use the data to drive systems change. There are also a number of federally funded initiatives that have created data collections that should be linked. For example, when the Department of Education funded Race to the Top, there was significant investment across the states to launch longitudinal data systems that track students from cradle to profession. There is rich data that is collected as part of these systems that could deeply inform health policy. Before creating another platform to collect this data we should inventory all the systems that are currently collecting population level data and understand how they could potentially be linked or leveraged.

- b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?

To start, we should not just focus on vulnerable populations. We need a health care system that looks at whole people. This includes social factors for all people. It’s important to track this data over time so we can use the data and identify tipping points or early warning signs that economic or social distress is setting in. Both have significant impact on health. As a first step, before a dollar is spent on technology, we should be focusing on intergovernmental data governance. We need to bring people together from across all levels of government to oversee how we are investing the collection of population level data. This governance should draw from program level

experts, front line delivery perspectives, policy makers, and technical teams. Governance should focus on collection standards, ethics, data needs and technology challenges. Governance can be instrumental in prioritization and safeguarding current and future investments from confusion, fraud and waste. Organizations that focus on governance first, spend less money on data collection and derive a much more significant benefit.

Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
“Empowered by Data: Legislation to Advance Equity and Public Health”
June 24, 2021

Faisal Syed, M.D., National Director of Primary Care, ChenMed

The Honorable Richard Hudson (R-NC)

1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.

a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?

While there may be value in such investments, I do not believe that would be the highest value place to invest. The greatest lever policy makers could pull would be to encourage and enable fully capitated (“budget based”) care – that is appropriately risk adjusted – where health providers own the risks of bad (expensive) health outcomes and the benefits of good health outcomes.

There clearly remains much to be learned about how to overcome social determinants of health and how to ensure the best health and wellness outcomes for people with social barriers. However, there are two issues to consider.

First is that research into best practices and the process of dissemination and adoption is a long process. It’s often [cited](#) that it takes 17 years for evidenced-based practices to become widely adopted. While research should be undertaken, we don’t have that long to wait for the payoff. Moreover, the best way to generate research is not to directly pay for it, but rather to create real world “learning laboratories” by giving providers the incentive to improve health for populations with social determinant of health challenges.

The second issue is that the system is not set up to encourage the needed learning, even with funding, because the foundational operating model remains “payment

by the piece” for what is billable in the existing healthcare system. Up to 80 percent of modifiable health outcomes are based on a person’s lifestyle, and the work of a health care professional to influence in that 80 percent is not on a fee schedule. It’s that work that is necessary to help populations struggling with complex social inequities and bring about equitable results. Said differently, healthcare delivery models that are based on the patient’s ability to pay (or the provider’s ability to bill) do not address social inequities because they only focus on the pathophysiology when medical conditions warrant immediate attention.

Fully capitated models take “ability to pay” and “ability to bill” out of the equation. Providers not only have the pre-established budget to invest in services, but they have the pressure to make sure they solve whatever issue – medical or social – is driving bad health outcomes. Investing in getting more providers to operate on these fully capitated models will create a natural learning lab where people can see what is working and emulate each other out of their aligned economic incentives to improving and equalizing health outcomes.

b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?

There are organizations collecting and organizing health care data based on social risk factors. The biggest problem, however, is that there is no standard. Which data elements must be captured? What possible responses (field values) should be in the answer option set? These are not defined and that undermines running useful performance research by appropriate population segments.

Secondarily, there is no incentive (“carrot” or “stick”) to gather important information beyond basics of age, gender, etc. Given the known inequities by socioeconomic, race/ethnicity, educational status, and more – plus the fact that 70 to 80 percent of modifiable health outcomes are based on social issues – there needs to be a forcing mechanism for providers to capture more defining data.

Coincidentally, moving more providers to capitation models (as described in the prior question) where business success relies upon finding the root cause of health issues and then addressing them, creates an incentive for more data capture. But, they still need standardization to capture data in a comparable way that allows for more study, more performance comparison across providers, and more identification of best practices in overcoming health inequities.

Attachment—Additional Questions for the Record

**Subcommittee on Health
Hearing on
“Empowered by Data: Legislation to Advance Equity and Public Health”
June 24, 2021**

Kara Odom Walker, M.D., M.P.H., M.S.H.S.
Executive Vice President and Chief Population Health Officer
Nemours Children’s Health

The Honorable Gus Bilirakis (R-FL)

1. As Co-Chair of the Rare Disease Caucus, I would like to focus some time on the disparity of care in sickle cell disease. The Trump Administration made great progress, including increased NIH research, and the approval of two novel therapies. I was also proud to support the enactment of the Sickle Cell Disease Research Surveillance Prevention and Treatment Act in 2018. But disparities in care remain — I am told of the 100,000 Americans suffering from Sickle Cell Disease — the great majority of whom are Black— only 30 percent of these 100,000 Americans receive any form of medical treatment despite its widespread availability.
 - a. What can Congress and the Administration do to break through and build on the Trump Administration’s progress in sickle cell disease, all the more important now that novel therapies have been approved with even more on the horizon?

Thank you for your work supporting Sickle Cell Disease (SCD) research and treatment activities that benefit patients and families nationwide.

As you mention, there are disparities in access to quality SCD care and health outcomes. The COVID-19 pandemic has worsened these disparities, as people of color have been disproportionately impacted by the health impact of the COVID-19 virus. One of several reasons behind this disparity is higher incidence of underlying comorbid conditions that increase risk of contracting COVID-19 and experiencing worse outcomes. SCD is one of the conditions identified by the Centers for Disease Control and Prevention (CDC) known to increase risk of severe illness from COVID-19.

Governmental support is critical to advancing SCD treatment and closing the disparities you have highlighted.

Nemours Children’s Health participates in a number of research, clinical and advocacy networks engaging in a spectrum of activities aimed at supporting individuals,

particularly children, with SCD. In 2020, Nemours received a \$10.5 million research grant from the National Institutes of Health (NIH) Center of Biomedical Research Excellence (COBRE) Phase II to establish and run the [Delaware Comprehensive Sickle Cell Research Center](#). The multidisciplinary Center works to strengthen early career investigator mentoring while further advancing biomedical research infrastructure for sickle cell disease research. The specific aims of the grant are: 1) Develop and oversee expert mentoring of early career investigators in research methods, research program development, and academic independence across an array of disciplines involved in the study of sickle cell disease; 2) Establish a diverse and inclusive grants program to promote the development of the next generation of sickle cell researchers in Delaware; and 3) Maintain administrative oversight that ensures strategic planning and development, compliance with all local and federal reporting requirements, and effective stewardship of resources to lead to the sustainable success of the Delaware Sickle Cell Research Center. The target projects included in the COBRE grant will explore the interactions of racism, stigma, and pain in sickle cell disease while evaluating ways to improve adherence to crucial disease modifying therapies. There is a particular focus on the adolescent/young adult population who are navigating the transition from pediatric to adult health care settings, a period of vulnerability marked by increased risk of morbidity and mortality. This research brings together our pediatric and adult health care systems to create comprehensive care addressing disparities across the lifespan. We would be happy to keep you updated on key findings from our work.

In addition, through our partnership with the American Society of Hematology (ASH), we support a legislative proposal to establish a Medicaid demonstration project to create a Medicaid delivery and payment model for SCD care. Such a demonstration would test models that aim to improve access to comprehensive, high quality outpatient care, including recommended clinical, mental health, ancillary, and support services, for individuals living with SCD who are enrolled in Medicaid, with an emphasis on targeting young adults and pregnant women with SCD.

A Centers for Medicare and Medicaid Services (CMS) report found that approximately 50% of the U.S. SCD population are covered by Medicaid. A second report found that almost 12,000 are covered by Medicare and of those, more than 8,000 are dual eligible for Medicare and Medicaid. We would welcome the opportunity to discuss this proposal with you and your team.

Congress should authorize a demonstration model that would allow states to apply for funding and test approaches to comprehensive care for individuals living with SCD, especially young adults and pregnant women.

The Honorable Richard Hudson (R-NC)

1. A number of public and non-profit safety net hospitals who serve large populations of low income and diverse patients who are challenged by numerous social risk factors have come together to share and innovate best practices. One major identified need is data platforms that track both medical and social conditions and facilitate access to services that respond to these needs. Another is support for “learning laboratories” that will advance identification and dissemination of promising innovations to improve care to these aforementioned populations.
 - a. Would you agree that investments into entities working to help advance best practices related to social determinants of health could drive progress in improving health inequity?

Investing in approaches to address individual and population-level social drivers of health (SDOH), including data platforms and sharing of best practices, would help drive progress in improving health equity.

With respect to data platforms, we support investments in community care coordination systems that provide tools to improve health outcomes by allowing bi-directional information sharing and referrals between health care providers and a full range of community-based service providers. Often referred to as “closed loop referral systems,” these data platforms can support the identification of social needs, referrals to services and feedback when the service is procured. Various Electronic Health Records (EHR) providers and technology companies have built referral systems for use across health care providers, community-based organizations, government agencies, and others.

However, we also recognize numerous challenges in the current ecosystem of closed loop referral systems. Interoperability is perhaps one of the most significant concerns. The simultaneous growth of numerous referral systems is already creating challenges. For example, when a major health system invests in a specific closed loop referral system, other health systems in the region are left with a difficult decision to either pay the fees associated with the closed loop referral system or choose to utilize a different system altogether, thereby contributing to a disjointed referral network. Community-based organizations find this especially problematic given their existing resource constraints and the challenges of managing multiple referral sources.

Some states are taking the lead in addressing this challenge. For example, North Carolina’s NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. NCCARE360 is made possible because of a public-private partnership between the North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation (FHLI). **This type of unified platform could be an emerging best**

practice that Congress could support through passage of the LINC to Address Social Needs Act of 2021 (S.509), which would establish statewide or regional partnerships to better coordinate health care and social services. We appreciate your leadership in working to introduce similar legislation in the House. Through public-private partnerships, states could leverage local expertise and technology to overcome longstanding challenges, helping to connect people to community resources to address social needs such as food, housing, child development, job training and transportation.

Furthermore, Congress could direct the Centers for Medicare and Medicaid Services (CMS) to highlight innovations like NCCARE360 and share best practices for their development and use with other states. CMS should also solicit feedback on ways to incentivize interoperability across these closed loop referral systems. The historical and ongoing challenges with EHR interoperability present a compelling case for federal government action in this increasingly competitive sector.

More broadly, Nemours Children's agrees that investments to advance best practices related to SDOH, whether through learning labs or other approaches, could have a positive impact on health inequity. Since 2017, Nemours Children's has supported 27 community networks via Learning Labs and we have found the approach to be promising. Participants from our Learning Lab project noted that their collaboration in the project helped to accelerate their work in their home communities, enabling them to achieve and exceed their community health goals. We found that a critical enabler of our Learning Labs was direct technical assistance to help advance their goals. Further, participants reported the benefits of the Learning Lab to be the creation of a safe space - a laboratory - to test ideas and approaches towards shared population health goals. **We encourage Congress to further explore learning laboratories as an approach to advance and improve outcomes.**

- b. What do you consider to be the investment of most immediate need in ensuring that health care, social risk, and other data are being collected on vulnerable populations and what do you see as the best steps for coordination among stakeholders on these efforts?

Nemours Children's considers investments in promulgating social drivers of health (SDOH) identification, collection of best practices and measurement to be the most immediate needs to ensure that health, social risk, and other data are being consistently and responsibly collected on vulnerable populations with their consent and engagement. Greater consistency across the country on how we capture and measure SDOH, with input and consent from patients and families, would provide an opportunity for authentic data to be utilized to help improve health.

Congress could help support and incentivize states and regions to identify and invest in a shared social needs platform for gathering that data. This would help to eliminate undue stress on our community programs from having to respond to multiple platforms and would make identifying social needs more efficient. Deidentified, aggregated social needs data can shed light on where the greatest inequities exist so that community partners and residents can work together to address root causes at the individual and population level. Coordination among stakeholders is a critical component for implementation of such efforts.

Additionally, we need [consistent measurement](#) of the impact of social drivers in federal payment programs. There are currently no approved social drivers measures in any Centers for Medicare and Medicaid Services (CMS) programs. CMS has included the first social drivers measures – focused on screening patients for food insecurity, housing instability, transportation, utility needs, and interpersonal safety – in its “measures under consideration” list. If approved, this would be a promising step forward, and we urge continued focus in this area.

Congress could support this work by encouraging CMS to advance the social drivers measures under consideration.