



Bipartisan Policy Center

COVID-19: Urgent Federal Actions to Accelerate America's Response

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FUTURE OF HEALTH CARE LEADERS

Tom Daschle

Co-Chair
Former Senate Majority Leader
Co-Founder, BPC

Bill Frist, M.D.

Co-Chair
Former Senate Majority Leader
Senior Fellow, BPC

Andy Slavitt*

Co-Chair
Former Acting Administrator,
Centers for Medicare and
Medicaid Services (CMS)

Gail Wilensky, Ph.D.

Co-Chair
Senior Fellow, Project Hope
Former Administrator, Health Care
Financing Administration (Now CMS)

Sheila Burke

Fellow, BPC
Strategic Advisor, Baker Donelson

James Capretta

Resident Fellow, Milton Friedman
Chair, American Enterprise Institute

Dan Crippen

Former Director, Congressional
Budget Office

Margaret Hamburg, M.D.

Former Commissioner of the Food
and Drug Administration

Chris Jennings

Fellow, BPC
Founder and President,
Jennings Policy Strategies

Risa Lavizzo-Mourey, M.D.

PIK Professor of Health Equity and
Health Policy,
University of Pennsylvania
Former CEO and President Emerita,
Robert Wood Johnson Foundation

William Roper, M.D.

Former Director, Centers for
Disease Control and Prevention

Avik Roy

Senior Advisor, BPC
Co-Founder and President,
The Foundation for Research
on Equal Opportunity

Mark Smith, M.D.

Clinical Professor of Medicine,
University of California San Francisco
Former Founding President and CEO,
California Health Care Foundation

Leana Wen, M.D.

Visiting Professor of Health Policy
and Management,
George Washington University
Former Health Commissioner,
City of Baltimore

*Mr. Slavitt has been appointed to serve as Senior Advisor to the COVID Response Coordinator for the Biden administration, and therefore is no longer affiliated with the Bipartisan Policy Center.

STAFF

Thomas Armooh

Project Assistant, Prevention Initiative

Tyler Barton, MPH

Research Analyst, Prevention Initiative

Anita Burgos, Ph.D.

Senior Policy Analyst, Health Project

Joann Donnellan

Senior Advisor, Communications

Lisa Harootunian, J.D.

Senior Policy Analyst, Health Project

Katherine Hayes, J.D.

Director, Health Policy

G. William Hoagland

Senior Vice President

Dena McDonough, PA-C

Associate Director, Health Project

Brady Newell

Project Coordinator, Health Project

Anand Parekh, M.D.

Chief Medical Advisor

Eleni Salyers, MPH

Research Analyst, Health Project

Marilyn Serafini

Director, Health Project

Kevin Wu

Policy Analyst, Health Project

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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Executive Summary

As it worsens, the COVID-19 pandemic is both revealing and creating extraordinary challenges to our nation's health care system and public health infrastructure.

Since the beginning of the pandemic a year ago, there have been more than 24 million confirmed cases, and more than 400,000 deaths across the country, accounting for 25% of the confirmed cases and 20% of deaths worldwide. After heart disease and cancer, COVID-19 was the nation's third leading cause of death in 2020. Communities of color are being disproportionately impacted, accounting for 40% of deaths. While on average 3,000 people a day are losing their lives to COVID-19 and hospitalizations are high, the pandemic is also creating a substantial economic loss, with millions of Americans experiencing unemployment and food and housing insecurity.

Given this backdrop, the Bipartisan Policy Center's Future of Health Care initiative reconvened in August 2020 and expanded its group of key health care leaders. Their mission: Develop recommendations that not only improve the resilience of America's health care and public health systems, but more urgently, address the threat of the coronavirus and the nation's response to it.

As a first step, in October 2020, the Future of Health Care leaders urged Congress to pass a short-term relief package that would allocate additional funding and resources for COVID-19 testing and contact tracing, vaccine distribution and monitoring, school COVID-19 safety, housing and nutrition assistance, health care providers serving disproportionately vulnerable populations, and states burdened by the health and economic disruption caused by the pandemic.

In late December 2020, Congress passed and President Trump signed into law a \$900 billion bipartisan relief package that addressed many of these issues. The bill included significant federal funding for vaccine distribution; COVID-19 testing, contact tracing, and mitigation efforts; nutrition and rental assistance; and health care providers, as well as needed financial resources for small businesses, unemployed workers, and American families.

In January 2021, President-elect Biden unveiled a \$1.9 trillion American Rescue Plan to further accelerate the nation's COVID-19 response and jumpstart the American economy. The plan includes \$400 billion to launch a vaccination program, expand testing and contact tracing, create a public health jobs

program to assist with the response, eliminate supply shortages, and assist schools with implementing COVID-19 safety protocols.¹ One day after taking office, President Biden released the *National Strategy for the COVID-19 Response and Pandemic Preparedness*, a comprehensive national plan to fight the current pandemic, and issued a series of executive actions to implement the response.²

These are important steps to help struggling Americans and gain control of coronavirus. BPC looks forward to working with the 117th Congress and the new administration to effectively implement the new law, achieve consensus on additional legislative action, and institute further actions necessary to save lives and reduce the transmission of the virus.

In this report, BPC's health care leaders outline short-term recommendations for immediate execution to address the challenges of the current pandemic.

The recommendations focus on six key issues:

- Testing and contact tracing
- Vaccine transparency, equitable distribution, and uptake
- Surge capacity
- Supply chain management
- Racial disparities
- State, local, and provider funding

KEY RECOMMENDATIONS

There are six key recommendations in this report with additional supporting recommendations for each.

1. Expanding COVID-19 Testing and Contact Tracing

Release a national testing strategy that outlines a path forward to reduce positivity rates in each state to under 5%. The strategy should detail how positivity rates should be defined, standardized, and reported by states; the amount and type of tests (e.g., diagnostic, screening) needed over the course of the pandemic; innovations in testing; use cases for existing tests; a user-friendly schematic for the public to understand which tests to obtain under what circumstances; guidance on payment for tests; a transparent analysis of the supply chain necessary for test production; and a timeframe to achieve the stated goals. The strategy should also detail the role of testing, particularly antibody testing, as vaccine administration progresses.

2. Ensuring Vaccine Transparency, Equitable Distribution, and Uptake

Launch a national COVID-19 vaccination campaign that ensures efficient vaccine distribution, so doses can be promptly administered, and educates Americans on the importance of obtaining a vaccine. The current lag between vaccine allocation and administration must be reduced through coordination at all levels—federal, state, and local—to ensure ample, publicly accessible and appropriately staffed sites for vaccine administration. A science-based communications strategy and education campaign should be tailored to subpopulations in order to maximize impact. It is also critical that health care professionals be a focus of the campaign, as their acceptance of the vaccine will instill confidence in their patients. States should also develop a specific strategy to vaccinate vulnerable populations and track vaccination rates, with a specific focus on communities of color, Tribal nations, older adults, low-income Americans, and those living in disparate geographic areas (rural and urban) to ensure gaps do not develop over time.

3. Supporting Health Systems' Surge Capacity

Direct HHS to engage in continuous quality improvement of its COVID-19 Hospitalization Dashboard and publicly disclose real-time health care system capacity data (e.g., ICU beds, staffing, PPE). An accessible and accurate dashboard will enable leaders at all levels of government to have better situational awareness and appropriately adjust community mitigation measures. This data will also help identify settings with adequate capacity for designation as relief health care facilities. While more granular facility-level data on bed capacity, hospital admissions, and emergency department visits is now available from HHS Protect, similar data on critical medical material (e.g., ventilators, medicines) and PPE would also be helpful.

4. Enhancing Supply Chain Management

Define and publicly communicate the roles, responsibilities, and authorities of agencies at the federal level to ensure that PPE and other critical medical materials are adequate. Clarifying functional roles will help federal agencies coordinate efforts to stabilize the supply chain, address supply issues rapidly, and ensure sufficient resources. A gap analysis of the PPE and critical medical materials required for the duration of the pandemic must be conducted to inform federal agencies as to when the Defense Production Act should be utilized to increase domestic manufacturing capacity.

5. Evaluating and Addressing Racial Disparities

Provide the CDC with the authority to require states and localities—working with health care providers—to submit race and ethnicity data on COVID-19 testing, cases, hospitalizations, and deaths on a regular basis. Currently, states report disaggregated data by race and ethnicity to the federal government on a voluntary basis. This policy change, coupled with new resources to enhance the nation’s public health data infrastructure, would allow policymakers to have access to consistent and comprehensive data to inform policy decisions that address the unique needs of communities of color.

6. Increasing State, Local, and Provider Funding

Provide an additional, one-time emergency appropriation for state and local public health departments with maximum flexibility to allow local officials to best meet the needs of their communities. While Congress recently passed a significant relief package with additional resources for COVID-19 testing, contact tracing, and vaccine distribution, it will be critical to monitor if states and localities have the resources that they need to address COVID-19, as well as other pre-existing public health challenges.

THE RECOMMENDATIONS ARE BASED ON FIVE GUIDING PRINCIPLES:

1. Political and public health leadership are central to successfully coordinating and managing a pandemic crisis.

Looking back to the 1918 influenza pandemic, we learned lessons that could have translated across a century to today’s public health emergency. The 1918 pandemic and the COVID-19 pandemic were and are highly political events. Leaders selectively chose what scientific results to recognize and, in some cases, ignored science and downplayed the seriousness of the illness; crowds continued to gather; cities shut down but reopened too soon; and people refused to wear masks. Successfully tackling a public health emergency of this magnitude requires federal leadership establishing a national plan paired with unified coordination and communications efforts across the country.

2. Trust in science and a commitment to public health are paramount to making progress in fighting a pandemic.

At the federal level, bipartisan leadership must support and elevate our nation's federal scientific agencies, allowing science to guide critical decisions in response to COVID-19. Leaders must emphasize the importance of science and effectively communicate the scientific basis of public health guidelines, particularly those that require economic or personal sacrifice of the American people. Restoring trust in our nation's health institutions and leading health experts will demand transparency at all levels with a focus on the safety, efficacy, and equitable distribution of treatments and vaccines. National and state leaders should lead by example and adhere to the scientific guidelines by wearing masks, physically distancing, and obtaining the vaccine. Trust in science, our health agencies, and scientists is imperative for reducing transmission, ensuring vaccine uptake, and successfully defeating the coronavirus.

3. National leaders must communicate and adhere to clear, consistent, and customized public health and safety messages and serve as role models.

Transparent communication with the American people will ensure people understand and trust the scientific process and the tools and actions needed to end this pandemic. When new evidence emerges prompting public health leaders to update their scientific advice, it is imperative to communicate with humility and transparency. Sharing and repeating clear, consistent, and customized public health messages by trusted leaders at the national and local level will help change the conversations between people and on social media where many people keep informed. Tailoring messages and public education campaigns to focus more on empathy than authority or politics and target specific communities will go a long way toward changing behavior and moving public opinion.

4. Federal, state, and local leaders—Democrats and Republicans—must take action to debunk conspiracy theories.

Conspiracy theories that have evolved around COVID-19 treatments and vaccines, even the existence of the virus itself, have been dangerous and put communities and individuals at greater risk of illness and death. Our political leaders need to speak out against these conspiracy theories and theorists and speak about what is actually known and true.

5. Federal efforts must recognize and address vulnerable communities.

Public officials must consider the unique experience of communities of color and other vulnerable populations, including seniors living in nursing homes and Native and rural Americans. There must be recognition of the need for political leaders to engage with the American public in a culturally competent manner. For example: They must understand and address deep-seated mistrust that many communities of color feel toward the medical establishment because of discrimination around access to care and medical research like the Tuskegee project. This pandemic exposed the need to focus attention on our nation's nursing homes where chronic conditions, understaffing, lack of accountability, and isolation have been hallmarks of COVID-19. An effective pandemic response must include a dedicated effort to address and mitigate the health disparities and unique challenges facing these vulnerable populations who are shouldering the burden of COVID-19 cases, deaths, and hospitalizations.

MOVING FORWARD

Over the next few months, BPC's Future of Health Care leaders will make additional recommendations on longer-term issues addressing future pandemics, including augmenting the public health infrastructure, bolstering health care capacity, improving federal interagency coordination during public health emergencies, reviewing federal health care coverage policies during a pandemic, and enhancing safety in congregate living facilities and transitions to home and community-based services.

“SO THE FINAL LESSON OF 1918, A SIMPLE ONE YET ONE MOST DIFFICULT TO EXECUTE, IS THAT...THOSE IN AUTHORITY MUST RETAIN THE PUBLIC'S TRUST. THE WAY TO DO THAT IS TO DISTORT NOTHING, TO PUT THE BEST FACE ON NOTHING, TO TRY TO MANIPULATE NO ONE.”

– JOHN M. BARRY, *THE GREAT INFLUENZA*

Introduction

Studies analyzing the arrival of the novel coronavirus causing COVID-19 in the United States suggest cryptic transmission in Washington state in late January and early February³ and possible community spread in California as early as December 2019.⁴

The nation's initial response was delayed due to limitations in surveillance and testing capability to detect and contain the virus. In addition, there were long-standing shortages of personal protective equipment (PPE), such as N95 respirators, and critical medical materials. This resulted in wide-ranging community mitigation strategies. For example, closures of nonessential businesses and stay-home orders were implemented to reduce transmission and the surge on the nation's health care system.

Re-openings allowed by state and local governments—many of which occurred too early and without adherence to recommended metrics—increased mobility, with many people ignoring mask use and physical distancing. This resulted in a second wave of cases over the summer, predominantly involving younger populations. The cooler fall climate prompted Americans to again congregate indoors. Pandemic fatigue, misinformation on issues such as the importance of wearing masks in public, and holiday gatherings and travel have now initiated a third wave of the pandemic—resulting in a record number of cases, hospitalizations, and deaths across the country.

The third phase coincides with the arrival of safe and effective COVID-19 vaccines. This significant scientific breakthrough was achieved through private sector ingenuity and the government's Operation Warp Speed. 38 million doses of vaccine have been distributed and tens of millions of additional vaccine doses are expected to be available in early 2021. Unfortunately, the early vaccine rollout has been plagued by a significant lag time between vaccine allocation and administration. As of mid-January, only 15 million Americans, representing approximately 5% of the population, had reportedly been vaccinated.⁵

The recent identification of several new variant strains of the SARS-CoV-2 virus has compounded the challenges. One specific variant, B.1.1.7—identified in the United Kingdom in December 2020—appears to be significantly more transmissible than prior strains. Although there does not seem to be a difference in severity of illness or concern about vaccine effectiveness at this time, the U.K. variant threatens to become the new dominant strain of the virus in 2021. Within one month, it had already been reported in dozens of countries, including the United States. Additional concerns are raised by other variants

that have emerged, including one from South Africa, 501Y.V2, which might compromise immunity.

These developments—the slow early rollout of the vaccine, the emergence of a more highly transmissible coronavirus, and the possibility that emerging variants could evade immune responses or influence vaccine efficacy, further underscore the continued importance of adhering to public health guidelines such as hand hygiene, respiratory etiquette, mask wearing, physical distancing, and eschewing public and large household gatherings for the foreseeable future. The emergence of new variants also underscore the need for adequate surveillance, including genomic screening and analysis.

Just prior to his inauguration, President Biden unveiled a \$1.9 trillion American Rescue Plan to accelerate the nation's COVID-19 response and jumpstart the American economy. The plan includes \$400 billion to launch a vaccination program, expand testing and contact tracing, create a public health jobs program to assist with the response, eliminate supply shortages, and assist schools with implementing COVID-19 safety protocols. He also articulated a 5-point vaccination strategy involving expanding priority groups for vaccination, increasing supply of vaccines utilizing the Defense Production Act, boosting the number of vaccination sites, surging staffing to help with vaccinations, and launching a campaign to address vaccine hesitancy.⁶ One day after taking office, President Biden released the *National Strategy for the COVID-19 Response and Pandemic Preparedness*, a comprehensive national plan to fight the current pandemic, and issued a series of executive actions to implement the response.

Moving forward with the pandemic response, public officials should communicate clearly about scientific developments in order to improve adherence to public health guidelines and ensure high vaccine uptake. Polling data shows approximately one quarter of Americans report vaccine hesitancy, with many citing a lack of trust in the government to ensure safety and efficacy of the vaccine and a perception of political interference in vaccine development.⁷ Science-based communication should be leveraged to overcome politicization and restore trust.

It will also be important to support Americans in coping with mental health and substance use issues exacerbated by the pandemic. Social isolation, the economic downturn, and the loss of friends and family to COVID-19 have increased rates of stress, anxiety, and depression.⁸ Furthermore, some preliminary evidence shows that prior psychiatric diagnosis is associated with increased risk of death among those hospitalized for COVID-19 infection.⁹ It is crucial for Americans with new and existing behavioral health issues to have access to behavioral health care to help recover from the devastating effects of the pandemic.

An effective pandemic response must include a dedicated effort to mitigate health inequities in underserved populations. Importantly, public officials should consider the unique circumstances facing communities of color and other underserved populations including low-income, rural, and Native Americans. Health disparities, particularly related to chronic diseases, in these underserved communities existed before COVID-19, largely due to social determinants of health such as housing and physical environment, income, race, education, workplace conditions, and access to healthy nutrition.¹⁰ The COVID-19 outbreak has only exacerbated these disparities. As a result, many underserved populations bear disproportionate burden of COVID-19 cases, deaths, and hospitalizations.¹¹

BPC's Future of Health Care leaders believe the new administration and Congress can optimize the nation's immediate response to COVID-19 by focusing on testing, vaccinations, surge capacity, supply chain, racial disparities, and state and local support. This report summarizes key recommendations for immediate action.

Recommendations and Policy Rationale

1. EXPANDING COVID-19 TESTING AND CONTACT TRACING

Background

Identifying and isolating COVID-19 cases through testing and subsequent contact tracing are essential public health strategies for suppressing virus transmission. Over time, a robust testing and tracing program will reduce case incidence by facilitating the quarantine of close contacts and interrupting chains of transmission. Test positivity rate—the number of positive tests over the total number of tests—is one marker of testing adequacy. The World Health Organization estimates rates exceeding 5% indicate insufficient testing.¹² According to the [Johns Hopkins Coronavirus Dashboard](#), 41 states have COVID-19 test positivity rates above that threshold; 23 of those have surpassed 10%. In addition, COVID-19 test results take 2-3 days on average, according to data analysis from a consortium of leading academic institutions. This exceeds the 2-day turnaround time necessary for optimal contact tracing.¹³

Testing capacity is also linked to supply chain limitations. Shortages of testing reagents, laboratory plastics, and specimen collection and transport supplies have been predominant barriers to an adequate testing strategy. These shortfalls have been consistent since the onset and existed prior to the pandemic. Notably, the recent surge in COVID-19 has put further stress on the supply chain, adversely impacting turn-around times.¹⁴

Prior to the most recent congressional relief package—which included \$22 billion for testing, contact tracing, and related mitigation efforts—Congress had previously appropriated \$26 billion for COVID-19 testing, including funding for state and local governments and federal agencies such as the Centers for Disease Control and Prevention, Biomedical Advanced Research and Development Authority, and National Institutes of Health. According to the COVID-19 Tracking Project, these federal efforts have contributed to more than 232 million completed molecular PCR tests to date and approximately 14 million tests weekly. While the majority of congressional funds dedicated to testing have been obligated, states have only drawn down and spent a limited amount.¹⁵

Groups such as the Rockefeller Foundation, Harvard Global Health Institute and Brown University School of Public Health, and the Association of American Medical Colleges have estimated the need for millions of rapid antigen tests,

in addition to molecular tests, each day to screen high-risk asymptomatic populations.¹⁶ Recently, the Trump administration announced its purchase and distribution of 150 million rapid antigen tests to be dispersed to long-term care facilities and to states to administer to high-risk populations. As of November 2020, approximately 25 million tests had been distributed to nursing homes, assisted-living facilities, Historically Black Colleges and Universities, Tribal communities, and disaster relief organizations; an additional 40 million tests had been distributed to states. To identify potential outbreaks before they occur, the administration recently stood up a Strategic Surveillance Program to aggressively and regularly screen certain communities for COVID-19 with rapid antigen or rapid molecular tests.¹⁷ The proliferation of rapid tests makes widespread serial testing in schools and essential workplaces possible. In conjunction with more detailed guidance on school and workplace safety (e.g., use of PPE, ventilation, physical distancing), regular testing could reduce transmission risk. By January, point-of-care testing volume was expected to reach almost 200 million tests per month.¹⁸ However, tests have been distributed without clear evidence-based guidance for use.

Experts at the Duke Margolis Center have estimated additional federal support is needed, including \$45 billion for screening of at-risk populations in high-risk settings over 18 months, \$24 billion for contact tracing, and \$6 billion to resolve supply chain shortages.¹⁹ The Families First Coronavirus Response Act requires all public and private insurance plans to cover medically appropriate, Federal Drug Administration-approved COVID-19 tests without cost-sharing. However, administration regulations have interpreted the statute in a way that mandates coverage for diagnostic purposes but not for screening asymptomatic populations as a component of public health surveillance.²⁰ Additional funding is also specifically required for contact tracing, given estimates that states have only half of the workforce required to adequately perform the necessary tasks to quarantine close contacts. President Biden's recently unveiled American Rescue Plan broadly calls for an additional \$50 billion to expand testing.

Recommendations

To ensure COVID-19 testing is widely available and sufficient for contact tracing efforts, the administration should:

KEY RECOMMENDATION

- **Release a national testing strategy that outlines a path forward to reduce positivity rates in each state to under 5%.** The strategy should detail how positivity rates should be defined, standardized, and reported by states; the amount and type of tests (e.g., diagnostic, screening) needed over the course of the pandemic; innovations in testing; use cases for existing tests; a user-friendly schematic for the public to understand which tests to obtain under what circumstances; guidance on payment for tests; a transparent analysis of the supply chain necessary for test production; and

a timeframe to achieve the stated goals. The strategy should also detail the role of testing, particularly antibody testing, once vaccine administration occurs. This is important as the presence and levels of antibodies could be used to monitor vaccine effectiveness over time.²¹

SUPPORTING RECOMMENDATIONS

- **Assign a “Tiger Team” with authority to act in accordance with a national testing plan to every state that has a positivity rate higher than 10% to assist local public health leaders in ascertaining why there is insufficient testing.** Interventions could include addressing a supply chain breakdown, diverting testing load to labs in states that are not at capacity, or increasing testing of high-risk asymptomatic populations. This would need to be coupled with public health recommendations, such as universal masking and policies promoting physical distancing to reduce the spread of infection.
- **Provide guidance to support the safe reopening and operations of schools and workplaces.** The FDA should continue to perform pre- and post-market evaluation of rapid antigen test accuracy and precision and offer guidance for manufacturers to improve upon current tests. In addition, the CDC should develop algorithms for the use of tests in specific at-risk populations and high-risk settings. Both agencies’ efforts should inform the NIH’s Rapid Acceleration of Diagnostics Initiative, which is striving to accelerate the development of fast, inexpensive, and reliable tests for widespread use. In addition, more research on understanding infectivity is necessary to ascertain the proper role for COVID-19 tests. If a surrogate measure for contagiousness can be identified, it could be used in concert with frequent rapid testing to potentially shorten quarantine periods and monitor contacts of cases more accurately.

To provide sufficient support for the expansion of COVID-19 testing and contact tracing, Congress should:

- **Request an estimate from the Biden administration as to the additional funding required to implement a national testing strategy and the plan for any unallocated funding from previous appropriations, including the most recent relief bill.** The funding request will likely depend on several assumptions including the duration of testing anticipated, costs of testing, the frequency and breadth of population-based testing of at-risk populations, and the number of contact tracers necessary to break chains of transmission.

As a general principle, regular population-based screening of at-risk populations (e.g., nursing homes, prisons, first responders, schools) should be funded by the federal government; businesses should largely cover the cost of screening their employees. Patients presenting to community-based

health care providers should have tests covered by health insurers without cost sharing. Tests for uninsured patients should be paid for by providers or public funds.

To complement testing with an early warning surveillance system, Congress should:

- **Support network-connected device systems (e.g., smart thermometers) and wastewater surveillance to locate COVID-19 hot spots and other infectious disease outbreaks.** Population-level illness data derived from sources beyond traditional health care settings could help decision-makers deploy testing and enact mitigation measures in targeted geographical areas.²²

2. ENSURING VACCINE TRANSPARENCY, EQUITABLE DISTRIBUTION, AND UPTAKE

Background

Two novel vaccine candidates from Pfizer and Moderna were granted emergency use authorization from the FDA after receiving a favorable vote from the agency's Vaccines and Related Biological Products Advisory Committee. The FDA had previously issued specific standards manufacturers would need to meet prior to submission, such as following trial participants for a median of two months, ensuring there are sufficient severe cases of infection in the placebo group, and demonstrating a 50% case reduction in the vaccination group.

While the willingness to take a COVID-19 vaccine has increased across all subgroups over the last few months, vaccine hesitancy is more pronounced in communities of color. A recent Gallup survey demonstrated 67% of white adults said they would get a vaccine, while only 53% of non-white adults said they would do so.²³ Other recent surveys have found specific gaps in the intention to be vaccinated between white adults and Black adults.^{24,25}

In addition, multiple anecdotal reports from the frontline of the early COVID-19 vaccination effort suggest significant rates of vaccine refusal among some health care workers and nursing home residents—groups at the top of the vaccine prioritization list.²⁶ This follows a recent Kaiser Family Foundation Health Tracking Poll indicating that 29% of health care workers would probably not or definitely not obtain a COVID-19 vaccine.²⁷

With respect to vaccine distribution, HHS released a draft vaccine distribution plan in the fall of 2020 and asked states to submit individual plans detailing various operational elements, including public communication strategies to increase education and awareness of COVID-19 vaccines. While states

submitted vaccine distribution and communication plans to the CDC, there was uneven consideration given toward vulnerable populations.

Perhaps more concerning has been the lack of federal support to states and localities in the form of resources, technical assistance, and best practices for quickly administering distributed vaccines. As of early this year, less than 50% of vaccines distributed have been administered.²⁸ This is likely due to a combination of factors, including vaccine hesitancy, overwhelmed health care systems, limited staffing, and insufficient planning and coordination across all levels of government.

The establishment of priority groups for vaccinations is necessary for vaccine distribution. To that end, the Advisory Committee on Immunization Practices provided states with preliminary guidance on vaccine prioritization. It's important to note that vaccine demand will outstrip supply, particularly in the initial stages of distribution. Specifically, initial individual allotments of vaccine doses will not fully cover priority groups such as health care workers (21 million people), essential workers (87 million people), older adults (53 million people aged 65 and older), and Americans with high-risk medical conditions (over 100 million people).²⁹

A review of state vaccine distribution plans reveals heterogeneity in approaches to prioritizing subpopulations within critical populations.³⁰ Some private sector groups have offered recommendations on how to prioritize within priority groups. For example, the Johns Hopkins Center for Health Security places health care workers caring for COVID-19 in a higher priority tier compared to health care workers with non-COVID-19 patient contact.³¹ The National Academies of Sciences, Engineering, and Medicine's framework for equitable allocation of COVID-19 vaccine places individuals with two or more designated medical conditions in a higher priority group compared to individuals with one medical condition.³²

The limited initial supply and distribution challenges have prompted consideration of novel approaches to vaccinating the public, including reducing the dose of individual vaccines or prioritizing a first-dose in as many people as possible so that there is at least some protection across large swaths of the population. There has not yet been a scientific consensus as to whether these strategies should be utilized in the United States. Most recently, President Biden's vaccination strategy calls for expanding priority groups to allow more people to be vaccinated and releasing the vast majority of vaccine as soon as it is available.

Finally, while vaccine distribution and prioritization has drawn attention, there has been less discussion about how the federal government should allocate the vaccine to states. Some experts contend that a per capita allocation strategy, like that undertaken during the 2019 H1N1 pandemic, would be inappropriate given the uneven distribution of priority groups and of subpopulations

disproportionately impacted across states.^{33,34} In addition, it is likely that allocation decisions will need to be made on a rolling basis, depending on the type and amount of vaccine ready for distribution.

Previous allocations by HHS of antiviral drugs, such as remdesivir, have been controversial and without optimal state and local coordination. More recently, the allocation of Bamlanivimab—a monoclonal antibody authorized for the treatment of mild to moderate COVID-19—on the basis of total state case counts did not take into account the size of high-risk groups and may also disadvantage rural states, many of which have a high per capita case count.

Recommendations

To increase COVID-19 vaccine uptake, particularly amongst communities with historically low vaccination rates, the administration should:

KEY RECOMMENDATION

- **Launch a national COVID-19 vaccination campaign that ensures efficient vaccine distribution, so doses can be promptly administered, and educates Americans on the importance of obtaining a vaccine.** The current lag between vaccine allocation and administration must be reduced through coordination at all levels—federal, state, and local—to ensure ample, publicly accessible and appropriately staffed sites for vaccine administration. Performance targets should be set, and there should be clear metrics and accountability for achieving progress. Federal assets (e.g., FEMA, National Guard) to support staffing and building additional community vaccination sites should be deployed.³⁵

President Biden has recently called for a “federally led, locally focused” vaccination campaign.³⁶ The science-based communications strategy and education campaign should be tailored to subpopulations in order to maximize impact. It is critical that health care professionals be a focus of the campaign, as their acceptance of the vaccine will instill confidence in their patients. It will also be important to communicate the continued need for vigilance regarding personal protective measures, even among those who have received the vaccine as we learn more about the real-world robustness and durability of the vaccine.

SUPPORTING RECOMMENDATIONS

- **Request that all states develop a precise strategy to vaccinate vulnerable populations, with a specific focus on communities of color.** It will be difficult for communities to reach herd immunity if significant subsections of the population remain unvaccinated. States should identify partner organizations and spokespersons that will help

build trust with communities of color to reduce vaccine hesitancy. This should specifically include partnerships with health care professionals in underserved areas, who are often uniquely trusted sources of information for their patients.

- **Request that states track vaccination rates across all racial, ethnic, age, income and geographic categories (rural and urban) to ensure gaps do not develop over time.** Real-time tracking would enable health officials to target outreach and public campaigns to subpopulations, limiting vaccination disparities. States should consider utilizing the CDC's Social Vulnerability Index, which identifies communities that may need support during a public health emergency. This would ensure specific geographical areas are not being left behind with respect to vaccination.³⁷

To ensure transparency of vaccine clinical trials data, the administration should:

- **Work with manufacturers to release all vaccine clinical trials data upon submission to the FDA.** This would allow independent scientific researchers and experts to review the data, raise questions arising with the FDA, and build public trust and confidence in the vaccine dissemination process. Increasing transparency of clinical trials data, in particular information on enrollment of racial and ethnic minority groups, may help to decrease vaccine hesitancy in skeptical communities. Post-marketing surveillance and full FDA approval of the vaccines over time will be essential, as well. Changes in vaccination strategies, such as first-dose prioritization or reducing the dose of an individual vaccine to extend supply, should only be considered if supported by data and evidence.

To allocate the COVID-19 vaccine equitably, the administration should:

- **Reevaluate the decision to allocate vaccine to states on a per capita basis in order to optimize saving lives and reducing viral transmission.** The administration should undertake an analysis of how to achieve both of the above goals and considers alternative allocation strategies and criteria (e.g., priority group population size, severity of outbreak). The administration should ensure final decisions are made through a transparent process.
- **Task the Advisory Committee on Immunization Practices (ACIP) to provide states guidance on how to create subgroups within prioritized groups.** With the sheer number of individuals in each priority group, it is unlikely individual vaccine allotments to states will cover entire groups. Strategies that assist with prioritization within priority groups could be helpful to states as they finalize distribution plans. As an example, the ACIP could provide guidance on which essential workers are at highest risk of contracting the virus so state prioritization plans are more uniform.

3. SUPPORTING HEALTH SYSTEMS' SURGE CAPACITY

Background

On January 1, 2021, approximately 125,000 people were hospitalized in the United States for COVID-19.³⁸ Hospitals report being overwhelmed, with many projected to reach capacity if current trends persist.³⁹ Concerns about shortages of beds, including ICU beds, and health care personnel are growing.⁴⁰ Earlier in the pandemic, hospitals in hot spots relied on hiring clinicians from other regions. Many states have modified medical licensure requirements and have granted temporary waivers for out-of-state clinicians to provide COVID-19 medical care.⁴¹ Cases are now high in all regions of the country, making it difficult for hospitals to address staffing shortages with clinicians from other states or regions, despite increased licensure flexibilities.⁴²

The National Disaster Medical System (NDMS) can deploy teams to provide medical and emergency management services and subject matter expertise, including assistance in health care settings.⁴³ NDMS teams have been deployed in response to over 300 incidents, such as Hurricane Katrina and the H1N1 pandemic.⁴⁴ A provision of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 aimed to increase medical surge capacity by improving the ability to pre-position NDMS teams.⁴⁵ A handful of NDMS teams were deployed early in the pandemic to assist in repatriation efforts and to set up of community testing sites.⁴⁶

In addition, the HHS Assistant Secretary for Preparedness and Response (ASPR) has authority to deploy the Medical Reserve Corps (MRC), a national network of 103,000 medical volunteers.⁴⁷ The HHS Assistant Secretary for Health oversees the US Public Health Service Commissioned Corps (USPHS) which can also help scale medical care.⁴⁸ As of October 2020, 4,800 of the 6,100 full-time Commissioned Corps officers have been deployed for various purposes.⁴⁹ However, it is unclear to what extent NDMS, MRC, and USPHS personnel have been assigned to provide direct medical assistance in health care facilities.

Most, if not all, major health systems have plans for maximizing system capacities during surges. ASPR's Medical Surge Capacity and Capability Handbook recommends information sharing, cooperative planning, and mutual aid among health care systems, but does not emphasize a unified command approach.⁵⁰ CDC has also offered guidance on mitigating hospital staff and bed shortages—recommending the hiring of additional personnel and transferring patients to alternate care sites or designated relief health care facilities with adequate capacity.⁵¹

The Centers for Medicare & Medicaid Services has enacted several flexibilities and regulatory waivers to help maximize health care system capacity, including

comprehensive lists of flexibilities for both hospitals and providers.^{52,53} For example, hospitals may screen and furnish inpatient or outpatient services at temporary expansion sites during the Public Health Emergency (PHE) under the Hospital Without Walls initiative.⁵⁴ Room and board, nursing, and other hospital services may also be offered at remote sites.⁵⁵ A temporary expansion of telehealth services has also been important for maintaining an adequate health care workforce and expanding surge capacity.⁵⁶

The HHS Protect Public Data Hub collects information from hospitals related to beds, staffing, and PPE availability.⁵⁷ At the beginning of the pandemic, the CDC utilized a previously established hospital data tracking system, but the White House Coronavirus Task Force shifted data collection to private contractors in July. An initial CDC analysis found that HHS Protect did not provide accurate data and was inconsistent with state-reported hospital data.⁵⁸ More recently, HHS has publicly released facility-level data on hospital utilization, and independent observers have noted significant improvements in accuracy as well as in the number of hospitals reporting.^{59,60} While there is now more granular data on bed capacity, hospital admissions, and emergency department visits in HHS Protect, similar granular data on critical medical material (e.g., ventilators, medicines) and PPE could also be helpful.

Recommendations

To ensure that health systems have enough capacity to accommodate surges in COVID-19 hospitalizations, the administration should:

KEY RECOMMENDATION

- **Direct HHS to engage in continuous quality improvement of its COVID-19 Hospitalization Dashboard and publicly disclose real-time health care system capacity data (e.g., ICU beds, staffing, PPE).** An accessible and accurate dashboard will enable leaders at all levels of government to have better situational awareness and appropriately adjust community mitigation measures. This data will also help identify settings with adequate capacity for designation as relief health care facilities. While more granular facility-level data on bed capacity, hospital admissions, and emergency department visits is now available from HHS Protect, similar data on critical medical material (e.g., ventilators, medicines) and PPE would also be helpful.

SUPPORTING RECOMMENDATIONS

- **Review how the NDMS, the Medical Reserve Corps, and USPHS have been utilized during the pandemic to support health system surge capacity.** These assets may not have been fully utilized to address workforce shortages. Staffing shortages are of primary concern for health systems, as traveling clinicians have been spread thin across the country's many hot spots. The Biden administration should review how these assets have been

deployed and identify appropriate opportunities to maximize utility of federal medical reinforcements to alleviate workforce shortages in clinical settings.

- **Direct CMS to maintain regulatory flexibilities for hospitals and health care providers to allow health systems to maximize surge capacity.** Flexibilities for telehealth, temporary expansion sites, and reporting requirements will continue to help maximize care delivery. A comprehensive assessment of how these flexibilities have been used can help to determine which specific flexibilities should be continued indefinitely or limited to the duration of the public health emergency.

4. ENHANCING SUPPLY CHAIN MANAGEMENT

Background

Authority over medical supply chain activities has been unclear and uncertain since the beginning of the pandemic response. On March 13, 2020, the federal government issued a COVID-19 response plan that established the Unified Coordinating Group—consisting of eight task forces, one of which was the Supply Chain Task Force.⁶¹ On June 15, the Supply Chain Task Force was reorganized into the Advisory Group and assumed an advisory and assistance role.⁶² In July and September, the Advisory Group’s responsibilities for monitoring commercial supply chain availability and making procurement decisions; DOD’s supply acquisition activities; and FEMA’s responsibilities for fulfilling state, local, Tribal, and territorial government’s requests for supplies began to be transferred to ASPR.⁶³ According to the Government Accountability Office (GAO), multiple federal, state, and local agencies have expressed confusion regarding supply chain management authority and identified the need to define roles and responsibilities as supply chain management authorities transition to ASPR.⁶⁴

Congress has provided funding from the CARES Act that federal agencies, hospitals, health care providers, and other entities can use to procure PPE and other critical medical materials, including \$16 billion for the Strategic National Stockpile (SNS) to procure PPE, ventilators, and other medical supplies.⁶⁵ From CARES Act funding, \$1 billion was dedicated to the Department of Defense for Defense Production Act purposes.⁶⁶

Federal agencies, such as the FDA and Federal Emergency Management Agency, have issued guidance and taken steps to address the shortage of PPE through the Supply Chain Advisory Group. On June 30, HHS and FEMA used targeted Defense Production Act Title I authorities to place priority on contracts to acquire ventilators, N95 respirators, and other items. As of August 15, HHS and DOD had utilized DPA Title III authorities to expand domestic production of medical supplies. Although the federal government has taken some steps to

mitigate shortages, there is still a significant shortage and demand for PPE and other critical medical materials.^{67,68}

The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 improved oversight of the SNS and clarified that using private-sector manufacturing capacity to procure necessary products should be considered. Congress appropriated over \$700 million to the SNS in FY2020.⁶⁹ Authority over the stockpile has been transferred multiple times, but it is currently under the oversight of the ASPR.⁷⁰ ASPR lacks the authority to sell SNS supplies to states or enter joint acquisition agreements with states, which inhibits supply acquisition coordination through the SNS.⁷¹

Although the federal government has taken steps to mitigate supply chain issues through DPA authorities and the SNS, challenges persist. According to a GAO report, the SNS did not have the capacity to adequately provide states with critical medical supplies at the scale of the COVID-19 pandemic.⁷² States and territories have faced challenges with procuring certain critical medical materials from the federal government.⁷³ In addition, roles remain unclear as states and territories have reported challenges in communication and partnership with federal entities.

President Biden's vaccination strategy calls on increasing vaccine supply to ensure a commitment to the two-dose schedule and supporting vaccine distribution by utilizing the Defense Production Act as needed.⁷⁴

Recommendations

To improve federal supply chain management activities and ensure PPE and other critical medical materials are adequate, the administration should:

KEY RECOMMENDATION

- **Clearly define and publicly communicate the roles, responsibilities, and authorities of agencies at the federal level.**⁷⁵ In the early course of the pandemic, responsibility of medical supply chain management was divided between multiple federal agencies and has now been restructured several times. Responsibilities began to be consolidated under ASPR in July, but a lack of clarity surrounding the agencies' responsibilities still exists. Clear definitions of roles, responsibilities, and authorities will help federal agencies coordinate efforts to stabilize the supply chain, address supply issues rapidly, and ensure sufficient resources.

SUPPORTING RECOMMENDATIONS

- **Direct ASPR, in coordination with partner agencies, to develop an information system to collect data on critical medical materials and supply chain capacities.** Private sector manufacturers should be able to share data with ASPR confidentially and allow ASPR to conduct critical gap

analyses. A central information system would inform agencies of actions needed to fill gaps.

- **Increase transparency of medical materials gaps and supply chain information.** ASPR and related partner agencies should publish information on which materials and supplies they have determined to be in short supply. Transparency is needed to help the private sector respond to shortages and contribute to manufacturing needs. Furthermore, federal agencies should be transparent about how they have exercised authorities in entering contracts and acquiring medical materials during the pandemic.
- **Develop and communicate plans that outline what specific actions the federal government will take to address supply chain challenges.**⁷⁶ These plans should specify how federal agencies intend to use the Defense Production Act in order to increase domestic manufacturing capacity of critical medical materials, including vaccines. HHS should coordinate with FEMA and DOD to define how each agency should contribute toward mitigating supply chain shortages. In addition, these plans need to be communicated clearly to stakeholders in order to ensure efforts to manage the supply chain are meeting demands for certain medical materials.

5. EVALUATING AND ADDRESSING RACIAL DISPARITIES

Background

Though COVID-19 continues to impact Americans nationwide, communities of color bear the greatest burden of COVID-19 cases, hospitalizations, and deaths. In November 2020, the COVID Tracking Project found mortality among Black Americans to be twice the rate of whites.⁷⁷ The disproportionate impact of COVID-19 on communities of color has been attributed to a variety of factors, including structural racism, pre-existing chronic diseases, and poverty, which were also recognized as drivers of health disparities prior to the COVID-19 outbreak.⁷⁸

Stark racial health disparities associated with COVID-19 have only recently been revealed partially due to insufficient state and federal data. Despite some improvements in state data collection, inconsistencies remain. As a result, many health professionals and policy makers cannot fully understand the breadth of health challenges in communities of color. In fact, many states report on either race or ethnicity, but not both. On the other hand, federally collected data tends to be more standardized than state reported data but does have its own limitations. For example, the federal data on hospitalization is collected from a small subgroup of only 250 acute care hospitals in 14 states.⁷⁹ Ultimately, the lack of quality race and ethnicity data can lead to inadequate resources for the most vulnerable communities.

It is unclear if there is an overarching strategy for optimal coordination of efforts across the executive branch. However, the Trump administration took steps to address some disparities exacerbated by the COVID-19 pandemic. To tackle data gaps, the administration focused on improving CDC data collection and reporting. One initiative, for example, is aimed at bolstering the CDC's demographic data by using surveillance and epidemiologic investigations to better understand the impacts of COVID-19 on vulnerable populations. This initiative, among others, sits within the CDC's larger COVID-19 Response Health Equity Strategy.⁸⁰ In June, HHS also announced new guidance specifying additional data (e.g., race, ethnicity, age, sex) laboratories must report to HHS along with COVID-19 test results. The CMS and the Health Resources and Services Administration have also begun reporting race-associated data. Despite these efforts, significant gaps remain in race and ethnicity data collection related to COVID-19 testing, cases, hospitalization, and deaths.

Evidence shows targeted and culturally competent messaging can improve health outcomes.⁸¹ During a pandemic, when collective responsibility and action are necessary, culturally appropriate communication is imperative. Prevention strategies in communities of color necessitate targeted outreach to instill trust in government, public health, and other institutions. Distrust in these entities is well-established, due to a history of unethical, targeted, government-sanctioned medical practices.⁸² As a result, individuals in communities of color express reluctance to participate in important public health and prevention strategies. Building institutional credibility in these communities must be leveraged to increase participation in testing, contact tracing, and vaccination efforts.

Recommendations

To ensure accurate race and ethnicity data is available to policymakers, Congress should:

KEY RECOMMENDATION

- **Provide the CDC with the authority to require states and localities, working with health care providers, to submit race and ethnicity data on COVID-19 testing, cases, hospitalizations, and deaths on a regular basis.**⁸³ Currently, states report disaggregated data by race and ethnicity to the federal government on a voluntary basis. This change would allow policymakers to have access to consistent and comprehensive data for informing policy decisions addressing the allocation of critical resources.

SUPPORTING RECOMMENDATIONS

- **Include additional funding for the public health data infrastructure in the next relief package.** Some states and localities do not have the infrastructure necessary to conduct comprehensive disaggregated data collection. However, more robust data is necessary to fill knowledge gaps

and drive informed policy decisions. Congress provided \$500 million over 10 years through the CARES Act to modernize the public health infrastructure, and an additional \$100 million in the most recent relief package. Many experts agree that more funding is needed to meet the growing demand on public health authorities. Indeed, the 2019 bipartisan Saving Lives Through Better Data Act (S. 1793) called for twice the annual amount provided in the CARES Act.⁸⁴

- **Direct the CDC to study the long-term health impacts of COVID-19 by race and ethnicity.**⁸⁵ Scientists have found increasing evidence highlighting the long-term health impacts of COVID-19 extending beyond the infection period.⁸⁶ Research is needed to understand these longer-term impacts on communities of color, which bear a disproportionate burden of infection and deaths.

To increase participation in critical prevention strategies among communities of color, Congress should:

- **Direct the secretary of HHS to develop targeted public health education campaigns.** The public education campaigns should be co-led by community-based organizations and disseminate COVID-19 information on mask-wearing in public, physical distancing, testing, self-care at home, and vaccine uptake in communities of color to decrease health disparities.
- **Provide funding for culturally competent contact tracing strategies.** Contact tracing helps public health authorities better understand community risk. In order to collect pertinent information, contact tracers often ask questions that require cultural sensitivity. For example, a contact tracer might ask community members about their food resources, living conditions, and work. Culturally competent contact tracers can encourage and retain community participation in prevention strategies by building trust with residents.

To improve coordination of federal efforts to address the disparate impact of COVID-19 on racial and ethnic minorities, the administration should:

- **Convene a White House-led interdepartmental Task Force on Racial and Ethnic Disparities in COVID-19.** The Trump administration did not establish a coordinated, multi-agency effort to address the disproportionate impact of COVID-19 on communities of color. The new task force should create policy solutions around data and reporting gaps, allocation of critical PPE, strategies to increase testing, and vaccine uptake to address the unique needs of communities of color. Additionally, many of the poor health outcomes in communities of color are exacerbated by chronic diseases and unmet social needs, which existed prior to the pandemic—such as poverty, lack of stable housing, and poor nutrition. The White House and other executive branch departments must address these critical social issues and the existing inequities that place racial and ethnic minorities at higher risk for contracting the virus.

6. INCREASING STATE, LOCAL, AND PROVIDER FUNDING

Background

In response to COVID-19, Congress and the Trump administration provided significant funding and regulatory flexibility to states, localities, and health care providers in order to meet the public health and health care needs of communities responding to the pandemic. This funding included:

- A 6.2% increase in the federal Medicaid match rate for states meeting certain maintenance of eligibility and continuous coverage requirements. This increase is in place until the end of the quarter in which the PHE ends.
- \$6.5 billion for the CDC, with \$2.4 billion available directly to states, localities, and territories to carry out surveillance, epidemiology, laboratory capacity, and other vital preparedness and response efforts in the first three COVID-19 response bills, plus additional funding in the most recent relief bill.
- \$600 million for public health data surveillance and analytics infrastructure modernization.
- \$600 million for the Infectious Diseases Rapid Response Fund, which was created to prevent, prepare, and respond to infectious disease emergencies, both domestically and internationally.
- More than \$9 billion to the CDC and states for COVID-19 and flu vaccine planning and distribution and \$20 billion BARDA for the procurement of vaccines and therapeutics.⁸⁷
- \$178 billion to the Provider Relief Fund for grants to hospitals and health care providers for expenses or lost revenues attributable to the pandemic and \$1.98 billion in emergency grant funding for Community Health Centers, including funding to support testing capacity.^{88,89} From the Provider Relief Fund, HHS targeted funds to safety net providers including \$18 billion for Medicaid and the Children's Health Insurance Program (CHIP) providers, \$11.3 billion for rural providers; \$9.4 billion for nursing homes; and \$14.4 billion for safety net and children's hospitals.⁹⁰ Concerns remain, however, that these funds are still not adequately reaching Medicaid providers, including community-based providers.⁹¹

As the pandemic has continued and worsened, these resources have been insufficient to meet the ongoing needs of the states and public health and health care communities in their COVID-19 response. National enrollment in Medicaid increased by almost 4 million between February and June of 2020—a 6.2% increase—placing additional demands on states and providers.⁹² Nearly half of states have reported that the funds provided to date have not been sufficient to address the negative economic impact COVID has had on safety net providers serving a high share of Medicaid and low-income patients.⁹³

According to a 2018 report, with input from BPC, the federal government has chronically underinvested in the state and local public health infrastructure.⁹⁴ State and local public health departments will need federal funding to continue to meet the challenges of COVID-19, including coordinating testing and contact tracing and facilitating future vaccine distribution. In addition, while the funding and flexibilities afforded to state Medicaid programs under the emergency declarations have enabled states to respond more effectively to the pandemic, the uncertainty around when those will end has made it more difficult for states to adequately plan and budget for the future. Under current law, the flexibilities end either with the PHE or shortly after.⁹⁵ The Medicaid and CHIP Payment and Access Commission, which advises Congress on Medicaid policy, has recommended that HHS provide states with sufficient guidance and lead time to minimize disruption for Medicaid beneficiaries, providers, plans, and states.⁹⁶

Safety net providers, state Medicaid programs, and public health departments are each critical for mitigating the spread of COVID-19, as well as better addressing social determinants of health, improving access to care for those with chronic conditions, and reducing health disparities in communities of color.

Recommendations

To ensure that state and local public health departments have the necessary resources to adequately respond to COVID-19—including conducting contact tracing, surveillance and testing activities, vaccine distribution, and the critical efforts to educate communities about the importance of vaccination, reduce vaccine hesitancy, and improve vaccination rates—Congress and the administration should:

KEY RECOMMENDATION

- **Provide an additional, one-time emergency appropriation for state and local public health departments.** This funding should have maximum flexibility to allow local officials to best meet the needs of their communities.

While Congress recently passed a significant relief package with substantial funding for critical public health activities, it did not include a direct, flexible allocation for state and local public health departments. Further, regularly monitoring state and locality needs and available resources to address COVID-19's demands on their public health systems is critical in the near term and equally as important for preparing for future public health challenges. The Association of State and Territorial Health Organization supports the \$13.7 billion that was included in the HEROES 2.0 legislation for the CDC to provide to state and local public health departments.⁹⁷ The National Association of County and City Health Officials recommends that Congress provide substantial investments to public health systems at all

levels while providing \$3 billion in funding specifically designated for local public health departments.⁹⁸

SUPPORTING RECOMMENDATIONS

- **Evaluate and provide additional federal funding to states and local jurisdictions as needed to enable them to effectively and efficiently distribute and administer the COVID-19 vaccine.** While Congress appropriated nearly \$9 billion for vaccine distribution in the most recent package, it is critical we continue to monitor vaccine distribution and ensure states have the resources they need. Funding is necessary to set up vaccination sites, support a vaccination workforce, procure PPE, ensure cold-chain storage and transportation of the vaccine, strengthen immunization information technology systems, and fund communication efforts.⁹⁹

To address the significant financial toll COVID-19 has had on many hospitals and health care providers, Congress and the administration should:

- **Allocate additional funding for the Provider Relief Fund, targeting resources to safety net providers, which serve a high number of Medicaid and uninsured patients, and providers who have faced particularly high COVID-19 caseloads.** As HHS allocates these resources, it should consider the disparate impacts that COVID-19 has had on the provider community and establish a consistent set of metrics to ensure funding is distributed to those providers most negatively impacted by the pandemic. This distribution must be prudent and transparent. Congress recently provided \$3 billion for the Provider Relief Fund, plus an additional \$6 billion in other financial assistance, but more help may be needed for struggling providers.
- **Provide an additional, one-time emergency appropriation for Community Health Centers to respond to COVID-19.** Both the House Democrats' HEROES 2.0 legislation and the Senate Republicans' HEALS Act included \$7.6 billion in additional funding for Community Health Centers to respond to COVID-19—with a focus on expanding testing capacity.

To ensure good governance and the appropriate use of federal funds, Congress and the administration should:

- **Ensure there is sufficient oversight and accounting of previous and future distributions from the Provider Relief Fund.** While these were emergency dollars that needed to be dispersed quickly, a thorough examination of the process and allocation is critical to good governance and will help avoid repeated mistakes in the future. In addition, Congress and HHS should ensure hospital reporting requirements remain consistent and do not disproportionately disadvantage safety net providers.¹⁰⁰

To provide budgetary and regulatory certainty to state Medicaid programs, enabling states to better plan their continued response to COVID-19 and minimize disruptions for Medicaid beneficiaries, providers, and plans, Congress and the administration should:

- **Extend the enhanced Medicaid Federal Medical Assistance Percentage to six months beyond the end of the public health emergency to provide states with increased budget certainty.**
- **Provide clear guidance to states for establishing Medicaid redetermination policies and processes when the maintenance of eligibility requirements created by the Families First Coronavirus Response Act expire to help states manage backlogs and prevent coverage disruptions.¹⁰¹**
- **Extend the regulatory flexibilities allowed in Medicaid and CHIP during the public health emergency to a date certain or for a longer duration beyond the national emergency and PHE declarations.¹⁰²**

Conclusion

Immediate action is needed to limit the threat of COVID-19, stabilize our health care system, and set the nation on a path to recovery. BPC's Future of Health Care leaders' recommendations represent a practical path forward, in which leaders set aside party politics to protect individuals and families. The health and economic impacts of the pandemic have also exacerbated long-existing disparities among Americans. These recommendations aim to provide those on the frontline with the resources and technical assistance they need to address the pandemic in an effective, evidence-based, and equitable way. Policymakers must act swiftly to rebuild trust in our public health institutions and encourage Americans to take up the actions necessary to combat the virus. BPC's leaders appreciate the significant resources Congress has provided for these efforts, thus far, as well as the executive branch's implementation efforts. These solutions are the next step to improve the nation's COVID-19 response, strengthen the resilience of America's health care system, and, hopefully, save lives.

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