

April 23, 2023

The Honorable Mariannette Jane Miller-Meeks, M.D.  
U.S. House of Representatives  
1034 Longworth House Office Building  
Washington, D.C. 20515

Submitted electronically to: [CDC.Reform@mail.house.gov](mailto:CDC.Reform@mail.house.gov)

**Re: Request for Information on Reforms to the Centers for Disease Control and Prevention (CDC)**

Dear Representative Miller-Meeks:

Premier Inc. applauds your leadership and ongoing commitment to improve our nation's public health and preparedness infrastructure through the release of a request for information (RFI) on how to best improve, reform and authorize the Centers for Disease Control and Prevention (CDC). Developing bipartisan legislation that considers lessons learned during the COVID-19 response and aims to improve the nation's preparedness infrastructure to respond to the next public health threat is vital. Premier further appreciates the thoughtful approach outlined under your leadership to seek stakeholder input in the development of consensus policy proposals and the acknowledgement that collaboration across the public and private sectors is essential to ensuring the nation's readiness and ability to proactively address future public health threats.

The existence of the CDC during the COVID-19 pandemic was instrumental in supporting the nation's rapid response, and as a nation, we would have been in a much worse situation had CDC's infrastructure not been available. However, lessons learned during the COVID-19 pandemic, and subsequently the Mpox public health emergency, demonstrated that there are opportunities to strengthen the CDC to be better responsive to public health needs during unprecedented times.

In our comments, Premier reflects on the lessons learned during COVID-19 and Mpox response efforts and provides recommendations to address the most critical public health challenges that demand increased attention. Specifically, Premier recommends revisions to the CDC to respond to public health challenges by:

- Leveraging technology to conduct syndromic surveillance to predict community outbreaks, prevent and control infections and automate tracking and reporting the spread of disease;
- Coordinating among the various government agencies leading public health emergency response efforts;
- Collaborating between the public and private sectors;
- Broadening and better organizing lab networks; and
- Continuing to leverage private sector healthcare data to conduct robust research on the short-term and long-term impacts of infectious diseases on public health.

**I. BACKGROUND ON PREMIER INC.**

Premier Inc. is a leading healthcare improvement company and national supply chain leader, uniting an alliance of more than 4,400 U.S. hospitals and health systems and approximately 250,000 continuum of care providers to transform healthcare. With integrated healthcare quality, cost and supply chain data and analytics, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data from nearly half of U.S. hospitals and 200,000 ambulatory clinicians. Premier is an agnostic, data-driven organization with a 360-

degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data-driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products.

Premier is also a leader in identifying, fulfilling and closing gaps in diverse sources for critical product categories – working directly with manufacturers to incentivize new manufacturers to enter the marketplace through programs such as ProvideGx for at-risk drugs and S2S Global for personal protective equipment (PPE) – a strategy that proved to be critical as the country looked to increase domestic manufacturing and identify new sources of critical supplies. Premier also identified and solved a major gap for continuum of care providers to obtain PPE and created an e-commerce platform, Stockd, to ensure continuum of care providers could access critical medical supplies.

Additionally, Premier has a long history of partnering with the government through initiatives such as managing one of the largest Centers for Medicare & Medicaid Services (CMS) demonstration models that led to the enactment of the hospital value-based purchasing program. As a government contractor, Premier has served as a trusted advisor and has a proven track record of positive results.

A 2006 Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government, and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare and ensuring healthcare providers have access to the right supplies, at the right time, to treat patients.

## **II. PREMIER'S LEADERSHIP IN COVID-19 RESPONSE EFFORTS**

From the beginning of the COVID-19 pandemic, Premier has been at the forefront of response efforts working around the clock to ensure hospitals, health systems, and continuum of care providers across the country had access to the necessary PPE, medical supplies and pharmaceuticals to treat COVID-19 patients. To meet the unprecedented demand, Premier:

- Used our global sourcing arm, S2S Global, to identify new sourcing of manufacturing capacity, ultimately contracting with seven different PPE factories across the globe to secure 36 million masks and respirators and 16 million gowns.
- Arranged cargo carriers and major airlines to expedite transportation of products so they could be onshore in hours, rather than months.
- Coordinated and allocated 2 million donated masks.
- Added 40+ new manufacturers of COVID-19 related supplies, including new domestic entrants of N95 masks, to our national contracts using an expedited review process to rapidly increase options.
- Worked with non-traditional and adjacent industries such as distilleries, textile manufacturers, and automobile manufacturers to fill supply gaps for essential products such as hand sanitizer, face shields, isolation gowns and surgical caps.
- Created an online exchange for health systems, Resilinc, to trade PPE supplies among one another, dynamically moving specific supplies to the neediest hot spots.
- Partnered with 15 health systems to acquire a minority stake in the nation's largest domestic supplier of PPE, such as masks and N95s, Prestige Ameritech.
- Partnered with 34 health systems to acquire a minority stake in a domestic supplier of isolation gowns, DeRoyal.
- Partnered with 80 health systems to invest in the domestic manufacturing of nitrile gloves alongside Honeywell.
- Partnered with 11 health systems to acquire a minority stake in Exela Pharma Sciences, LLC, to secure vital supply of pharmaceutical products and support domestic production.

- Leveraged our existing drug shortage program, ProvideGx, to secure additional safety stock and dedicated supplies, thereby avoiding shortages for many critical products including propofol which is essential for ventilating patients and emergency syringes which are essential for resuscitating patients.
- Vetted thousands of gray market solicitations on behalf of our members and reported hundreds of illegitimate sellers to the authorities.
- Managed the supply chain operations for 11 health systems in the New York-New Jersey-Connecticut tri-state region during COVID-19.
- Through our Nexera program, supported various entities with the New York City government including the Mayor's office, NYC Office of Emergency Management, Department of Health and Mental Hygiene, Department of Education and NYC Department of Citywide Administrative Services over the past three years in multiple COVID-19 pandemic response efforts for the healthcare supply chain - from emergency sourcing support, PPE and ventilator stockpile operational strategy development, stockpile operations, rapid test kit operations and more.
- Provided support, resources and products for our members, both acute and continuum of care, to establish programs such as testing centers, vaccination programs, hospital-at-home programs and telehealth services to best support the communities they serve.
- Participated in The Federal Retail Pharmacy Therapeutics Program (FRPTP) to increase access to COVID-19 vaccine for long-term care residents.

In addition, Premier has worked closely with the Administration to provide data on surge demand, clinical utilization, and barriers to providing care and improving healthcare delivery during the pandemic. This work resulted in numerous waivers, regulatory flexibilities and guidance documents that were critical during the public health emergency to prevent infection, avoid unnecessary hospitalizations for ambulatory conditions, increase availability of PPE and medical supplies, and more.

Premier also played the organizing and leadership role in the creation of the COVID-19 Private Sector Supply Chain Coalition, which was established to coordinate an integrated, public-private supply chain response to the challenges created by the COVID-19 pandemic. The Coalition served as a single coordination point for the government to share non-competitive, non-pricing information, best practices and strategies among key parties in the healthcare supply chain to promote the efficient management of supply and distribution during the COVID-19 pandemic. The Coalition's primary goals were to promote public and private sector cooperation, strengthen the healthcare supply chain, and speed answers to urgent supply challenges across hospitals and other U.S. healthcare providers. The coalition shifted its work to a standing organization, with Healthcare Ready serving as the coordinator, at the end of 2020.

Premier has also worked closely with Congress to advance needed reforms to address public health and supply chain issues. This included playing a leadership role in working with healthcare organizations, federal agencies and lawmakers to pass sections 3101, 3111, 3112, and 3121 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act to mitigate drug and device shortages necessary for patient care during the pandemic.

Finally, Premier's leadership in COVID-19 response efforts and expertise in supply chain issues was recognized by the appointment of Premier to the executive committee of the [Joint Supply Chain Resiliency Working Group](#) which is charged with ensuring that the path to a more resilient healthcare and public health supply chain is jointly established by the federal government and industry partners.

### **III. PREMIER'S REFLECTIONS & LEARNINGS FROM COVID-19 RESPONSE EFFORTS**

Premier has spent significant time reflecting on the experience of the healthcare industry during COVID-19 response efforts to determine elements that worked well as well as areas of improvement for the future. Premier's reflections have found that:

- Elements that Have Worked Well:

- Nimbleness and ingenuity of the private sector to anticipate and identify needs as well as respond quickly to fill gaps.
- Formation of the Private Sector Supply Chain Coalition to provide a coordinated and collaborative response to the government and in the market.
- Sharing of supply chain data that accounted for both supply and demand from neutral, vendor agnostic, and value-orientated entities.
- Regulatory flexibilities and waivers from FDA, CMS, HRSA and CDC that were delivered rapidly.
- Timely and regular access to government leaders and openness to input, including swift action to assist states and regions when requested.
- Elements that Led to the Current Situation and Points of Failure:
  - Despite efforts by Premier and others to counter the trend, a focus for the past 20+ years to move manufacturing offshore as a means to reduce costs to offset decreasing healthcare reimbursement. This is because emerging economies:
    - Are more willing to take greater environmental regulatory risks;
    - Have large populations of low-cost labor; and
    - Have tax incentives to move manufacturing to their markets.
  - Lack of centralized upstream visibility into supply chain to determine source of raw materials and finished goods. This resulted in diminished understanding of vulnerabilities, foreign reliance on manufacturing, and impact as export bans and manufacturing shutdowns were announced.
  - Unprecedented demand both globally and nationally that led to an imbalance in the supply vs demand, e.g., 17 times increase in surge demand for N95 masks.
  - Export bans and manufacturing shutdowns globally.
  - Insufficient supplies in the Strategic National Stockpile (SNS) to address a global pandemic and cumbersome process for accessing supplies in the stockpile.
  - More reactive approach vs a proactive approach by the government at the outset. Product was not allocated to “hot spots” (aka areas of greatest) need because there was not clear identification of them until much later.
  - Fragmented approach to securing supply (private sector vs federal vs states) led to product access issues and an increase in prices as multiple entities competed for the same inventory and out-bid one another. This led to competitive friction between national and state stockpiles when all stockpiles should have been working together to move product to the areas of greatest need.
  - Lack of clear visibility of distributor fulfillment led to uncertainty on where products were delivered. This continued uncertainty left providers with dwindling confidence in the normal supply chain and proliferated more maverick and forward buying, as well as hoarding. This also led to a rampant gray market and many entities purchasing counterfeit products.
  - Insufficient national strategy and plan for addressing global pandemics, including confusion regarding which federal agency was responsible.
  - Existence of patent restrictions that impeded access to ancillary products needed for care such as viral swabs.
  - Port congestions and delays in global logistics nearly doubled and tripled product lead times resulting in supply shortages due to an inability to prioritize healthcare supplies.

#### **IV. LEADERSHIP STRUCTURE AND “MOVING FORWARD” REORGANIZATION**

As noted in the RFI, a Health and Human Services (HHS) review of the CDC’s handling of the COVID-19 outbreak prompted CDC Director Walensky to acknowledge that the agency “did not reliably meet expectations” and to embark on an overhaul of the agency’s operations and culture. While this is a positive step in the right direction, it is critical that Congress reflect on the entirety of the federal government’s approach to the pandemic and solidify oversight and management structures to ensure a cohesive federal response for future public health emergencies.

With the national response to COVID-19, the array of responding federal and state agencies had little insight into what their counterparts were doing, leading to overlaps, conflicts and duplication. With Mpox, the Assistant Secretary for Preparedness and Response was elevated to an operating division within HHS in 2022 and is now known as the Administration for Strategic Preparedness and Response (ASPR). With the elevation to an operating division, it was noted that ASPR “leads the nation’s medical and public health preparedness for, response to, and recovery from disasters and other public health emergencies.” Seemingly, this indicated the ASPR would take point on future pandemic response and alleviate much of the confusion that existed during the early days of the COVID-19 pandemic regarding which federal agency was leading response efforts.

However, shortly after ASPR’s elevation a public health emergency for Mpox was declared. While many anticipated that ASPR would be named to lead response efforts given its newly elevated role and mission, it surprised many when officials from the Federal Emergency Management Agency (FEMA) and CDC were named as the primary and secondary leads for the Mpox response.

Furthermore, the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes within the Executive Office of the President an Office of Pandemic Preparedness and Response Policy creating further confusion regarding the role of this new office versus ASPR, FEMA and the CDC.

Therefore, ***Premier recommends that Congress help clarify the roles and responsibilities of the CDC and other federal agencies during a pandemic response and articulate which agency, or agencies, should lead response efforts during a pandemic.***

## V. DATA AND SURVEILLANCE

### **Syndromic Surveillance to Predict Community Outbreaks**

In the early days of the pandemic, Premier leveraged clinical decision support, powered by machine-learning, artificial intelligence and natural language processing, to effectively predict COVID-19 surges and regional flare ups well before patients started showing up at the hospital for treatment. Armed with positive results, Premier advocated for federal agencies to adopt a national system for syndromic surveillance to better track and predict outbreaks – and quicken response times.

Symptoms are the earliest and most reliable indicator of the emergence of infectious diseases that threaten our nation’s public health. Identifying suspected cases early is the best signal of the need to take action. However, a recent Government Accountability Office (GAO) [report](#) notes how a lack of federal action to modernize the public health data infrastructure seriously undercut efforts to combat the COVID-19 virus. This is a situation that was unfortunately replayed with the Mpox public health emergency.

***America needs an automated, near real-time means to collect symptoms and confirmed case information consistently and comprehensively so that it can be shared between and among multiple public and private stakeholders, including federal, state, local, Territorial and tribal public health authorities as well as on-the-ground providers.*** Such a system can pull in information on symptoms, comorbidities and other vital information, allowing for targeted tracing and interventions to proactively prevent outbreaks. Earlier recognition of new hot spots speeds quarantining of potentially infected persons, reduces the spread of the virus and saves the nation money on contact tracing and testing. This reality is possible today and Congress should push federal agencies to explain how a system that was required under the Pandemic and All-Hazards Preparedness Act (PAHPA) in 2006 is still not operational today. In lieu of trying to remedy an antiquated 20+ year system, Congress should push CDC to start fresh by adopting 21<sup>st</sup> century technology.

### **Automated Tracking and Reporting the Spread of Disease**

During the COVID-19 pandemic, virtually all reporting was done using paper-based forms that were then faxed back to the state and local public health departments for recording and follow up. Reporting was limited to hospitals providing treatment for the most severe cases and labs that encountered a positive COVID-19 test. This meant public health agencies received no information from milder cases diagnosed in a physician office, or from patients self-diagnosed via at-home tests.

Fast forward to Mpox and some improvements in reporting were made. Any labs performing a Mpox test were required to report all results directly to public health departments and were strongly encouraged to submit this data electronically, as opposed to via paper forms.

However, electronic reporting is still not a requirement and public health case investigation forms used to track the source of transmission are still paper based and very lengthy (e.g. more than six pages long for Mpox). ***The federal government should require and prioritize efforts for automated, streamlined nationwide public health data collection, exchange and sharing using data and interoperability standards.***

### **Infection Surveillance, Control and Prevention in Long-term Care Facilities**

COVID-19 has brought to the forefront the specific challenges nursing homes face in containing the spread of infectious disease. The virus accelerated at nursing homes because residents are generally vulnerable to its complications and more susceptible in the contained space of facilities. While data about infections in nursing homes is limited, the CDC notes that, even prior to the pandemic, a staggering 1 to 3 million serious infections occur annually in these facilities and as many as 380,000 people die of infections in nursing homes every year.

Infection prevention oversight and training at nursing homes is a challenge in and of itself with limited staffing and several layers of reporting requirements. This challenge is compounded by limited Electronic Health Record (EHR) functionality at the sites. Without a comprehensive infection prevention surveillance workflow, the surveillance, tracking, documenting and reporting of epidemiologically significant organisms and infection is difficult for everyday risks, such as multi-drug resistant organisms, but also when an outbreak like COVID-19 occurs.

Clinical analytics technologies are currently widely leveraged in hospitals and acute setting to detect patient care issues through surveillance, interventions and reporting capabilities that are needed to support antimicrobial stewardship programs. These systems utilize data from EHRs and have significantly helped clinicians and pharmacists in acute settings identify overuse of antibiotics and drug-bug mismatches, reduce time-to-appropriate therapy and enhance therapy for difficult-to-treat pathogens. Those health systems already utilizing clinical surveillance technology were well positioned to respond to COVID-19 before the pandemic hit.

Unfortunately, clinical analytics technologies are currently not widely used in nursing homes and other long-term and post-acute (LTPAC) settings. These settings should have the same access to tools that will help them combat infection spread during any future disease outbreaks and during their day-to-day operations, but unfortunately funding remains a significant barrier as programs authorized and funded under the Health Information Technology for Economic Clinical Health (HITECH) Act excluded LTPAC providers. These entities are already challenged with meeting their more visible needs, such as testing and securing adequate PPE levels at their sites, but a more comprehensive approach is needed to ensure data collection is efficient, non-duplicative and being analyzed in ways that are helpful for facilities. Furthermore, it is critical that lessons learned from meaningful use are applied forward as we develop cohesive solutions to address the lack of EHRs and clinical surveillance technology in nursing homes and create appropriate incentives for adoption.

***Premier encourages Congress to consider policies that incentivize nursing homes and other LTPAC providers to implement EHRs and electronic clinical surveillance technology to provide meaningful assistance with infection control.***

## **VI. PUBLIC-PRIVATE COLLABORATION**

From the early days of COVID-19 and through today, the public and private sectors have come together in unprecedented ways to tackle these “once in a century,” pandemic-driven challenges, which has entailed:

- Developing and distributing life-saving vaccines and treatments in record time;
- Driving research and the practice of medicine forward; and
- Creating the Private Sector Supply Chain Coalition and the Administration’s [Healthcare and Public Health \(HPH\) Sector Joint Supply Chain Resilience Working Group](#) comprised of group purchasing organizations, distributors, manufacturers and others that share invaluable information on the current state of the supply chain and strategies to increase available supplies.

***Continued information-sharing and collaboration will help ensure a path to a more agile and robust response to public health emergencies jointly by the federal government and industry.***

As a prime example, the Strategic National Stockpile (SNS) should establish a public-private advisory council that includes representatives from the private sector such as manufacturers, group purchasing organizations, distributors, physicians, pharmacists, nurses, laboratorians, non-acute providers, patients, professional associations, and others as well as representatives from the public sector such as federal agencies (HHS, FEMA, ASPR, CDC, CMS, FDA, SAMHSA, the Veterans Health Administration, Indian Health Services, etc.), prisons, first responders, state and local representatives, and others. The advisory council should leverage a multi-committee structure to ensure the appropriate expertise is represented for specific product categories such as pharmacy, lab, nursing homes, pediatrics, etc. The advisory council will be critical to ensuring the SNS is soliciting feedback from a broad range of entities to augment its operations through a data-driven approach, remain unbiased and vendor agnostic, support a collaborative decision-making process, identify innovative products, and continuously refine the vision of the SNS. Essentially, the advisory council structure helps ensure the SNS is built by providers for providers.

To accomplish this, statutory changes are required to amend the composition of the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), the group responsible for dictating the contents of the SNS. The PHEMCE is currently led by ASPR and includes three primary HHS internal agency partners: the CDC, the Food and Drug Administration (FDA) and the National Institutes of Health (NIH), as well as several interagency partners: the Department of Defense (DoD), the U.S. Department of Veterans Affairs (VA), the Department of Homeland Security (DHS) and the U.S. Department of Agriculture (USDA). The PHEMCE currently does not include private sector feedback. This was also highlighted in a recent National Academies of Medicine report, [Ensuring an Effective Public Health Emergency Medical Countermeasures Enterprise](#), that provides recommendations from an expert committee for a re-envisioned PHEMCE. Therefore, ***Premier recommends that Congress amend the composition of PHEMCE to include private sector representation and create a true public-private advisory council.***

## **VII. EPIDEMIOLOGY AND LABORATORY CAPACITY GRANT PROGRAM**

Early COVID-19 testing was plagued by a lack of testing locations, a shortage of specimen collection swabs, inadequate lab capacity to process tests and sporadic genomic sequencing to monitor for variants. With Mpox, efforts to speed access to testing were swifter as the CDC effectively onboarded commercial labs to expand testing for Mpox within one month. While an improvement, that one month delay did have consequences creating testing bottlenecks.

As we learned during COVID-19, delays of even a day can have dire effects on limiting transmission. Instead, ***the government should broaden and better organize the lab network to include hospitals, academic medical centers, and regional testing laboratories that have the ability and capacity to perform these tests in their communities.*** Broadening the lab network will help ensure that regionally based testing can produce more timely results, empowering immediate and effective public health action. It is also critical for the nation to develop a genomic sequencing strategy for Monkeypox to stay ahead of potential variants.

## VIII. CDC AUTHORIZATION

Throughout the pandemic, a rate limiting step in federal agency response was contracting and hiring authority. While some agencies had more flexibility to increase resources to meet the task at hand, other agencies did not have the same authority or flexibility to increase their staff. To better respond to future pandemics, ***Premier urges Congress to ensure all federal agencies with a potential role in response to a future pandemic have similar contracting and hiring authority to expeditiously obtain the resources necessary to adequately carry out their duties.***

## IX. EVIDENCE GENERATION

One area where Premier believes the CDC excelled throughout the COVID-19 pandemic is evidence generation by leveraging private sector data sets to publish a multitude of studies evaluating the short-term and longer-term impacts of the disease on public health. Specifically, the CDC leveraged Premier's PINC AI™ Healthcare Database (PHD) which has [captured](#) more than 5 million confirmed COVID-19 patients who were treated in inpatient and outpatient settings across 956 U.S. health systems and more than 3.5 million patients who received a COVID-19 vaccine in these hospitals and health systems. With a lag time of approximately 60-90 days and detailed clinical data on hospital visits that include treatments, comorbidities, diagnoses, procedures, microbiology, general labs, vital signs and imaging, the PHD is one of the most comprehensive and timely databases driving research and providing answers to the toughest COVID-19 related questions.

As of July 2022, the [CDC has published 27 COVID-19 related research studies](#) using PHD data in CDC's *Morbidity and Mortality Weekly Report* and peer-reviewed journals. Some of these studies include:

- **Is COVID-19 linked to a higher risk of myocarditis?** Viral infections are a [common cause of myocarditis](#), an inflammation of the heart muscle that can result in hospitalization, heart failure and sudden death. During the pandemic, the CDC sought to understand if COVID-19 was associated with a higher risk of myocarditis. In their [study](#) using PHD data, they found:
  - The occurrence of myocarditis inpatient encounters in 2020 was 42 percent higher than pre-pandemic (in 2019).
  - The risk for myocarditis among patients with COVID-19 was nearly 16 times higher than patients without COVID-19 during the pandemic.
  - The association between COVID-19 and myocarditis was more pronounced among children (younger than 16 years old) and older adults (50 years old and older).

They found that while myocarditis was uncommon overall, a diagnosis of COVID-19 significantly increased a patients' risk of myocarditis.

- **What were the trends around antibiotic use during the pandemic?** [Antimicrobial resistance](#) is a major concern, killing at least 1.27 million people worldwide with more than 2.8 million antimicrobial-resistant infections occurring in the U.S. each year. In a [recent retrospective study](#) using PHD data, the CDC sought to understand antibiotic use trends during the pandemic.

Observing data from 716 hospitals that reported at least 100 antibiotic days of therapy per 1000



patient days from March to October 2020, they found that 77 percent of inpatients hospitalized with COVID-19 received antibiotics and 81 percent of them were started on admission — even when data showed limited reported [evidence](#) for bacterial coinfections among COVID-19 patients.

Antibiotic stewardship programs are an essential component in antimicrobial resistance efforts and health systems can [leverage](#) their infrastructure to address challenges that COVID-19 presented. Even during a pandemic, antibiotics should be used responsibly and sparingly to help avoid unintended long-term consequences associated with overuse.

- **Were patients with Type 1 diabetes at a higher risk for serious complications?** In one [CDC study](#), researchers investigated whether patients hospitalized with COVID-19 and Type 1 diabetes mellitus (T1DM) were at a higher risk for severe outcomes.
  - Utilizing PHD data, they found that COVID-19 patients with T1DM had a 21 percent higher risk of intensive care unit (ICU) admission and invasive mechanical ventilation (IMV) use compared to COVID-19 patients without T1DM.
  - Although the risk of ICU/IMV was 9 percent higher among patients with T1DM than those with T2DM, the difference attenuated after accounting for diabetic ketoacidosis. Patients with T1DM had a 5 percent higher risk of mortality than patients without diabetes.
- **Did body mass index (BMI) play a role in severe COVID-19 outcomes?** Obesity [affects](#) 42.4 percent of U.S. adults and is a [recognized risk factor](#) for severe COVID-19, [impaired lung function](#) and other chronic diseases. One [CDC study](#) using data from the PHD assessed the association between BMI and severe COVID-19 outcomes. The findings included:
  - Among patients with a COVID-19 diagnosis and in emergency department or inpatient care, 28.3 percent were overweight and 50.8 percent had obesity.
  - Obesity was a risk factor for hospitalization and death, and risks increased with increase in BMI categories.
- **Did COVID-19 adversely affect pregnancy outcomes during the pandemic?** In a [cross-sectional study](#) of U.S. delivery hospitalizations, the CDC leveraged PHD data to assess differences in select maternal and pregnancy outcomes between April through December in 2019 and 2020.

In-hospital maternal death increased from 2019 to 2020, while maternal ICU admission and preterm births decreased. However, there was no significant difference in maternal death after excluding deliveries with a COVID-19 diagnosis. The proportion of cesarean deliveries with pre-labor rupture of membranes (PROM), prolonged labor, and attempted forceps or vacuum slightly increased, as did high-risk cesarean deliveries in 2020 compared to 2019. Researchers saw an increase in gestational diabetes from 8.4 percent in 2019 to 9.8 percent in 2020. Overall delivery length of stay (LOS) was shorter in 2020 compared to 2019.

- **What were the trends associated with severe COVID-19 illness?** Clinical severity of COVID-19 ranged widely from asymptomatic infection to multiorgan failure and varied over time as new variants emerged. One PHD data-informed [CDC study](#) analyzed the severity of acute illness trends over time among hospitalized patients with COVID-19 in the U.S.

Findings demonstrated that clinical severity of hospitalized COVID-19 patients fluctuated over time, but no evidence was found for consistent worsening of COVID-19 severity between April 2020 and April 2021.

Severity in COVID-19 illness tended to be lower among women, younger adults and those with fewer comorbidities compared to their counterparts. In addition, severity across racial and ethnic groups tended to be similar.

- **How substantial was the cost for COVID-19 inpatient care during the pandemic?** A recent [CDC study](#), using PHD data from more than 800 hospitals covering all payers in the U.S., assessed the average per-patient cost of inpatient care for hospitalized adult COVID-19 patients, overall, and by severity, age, sex, underlying medical conditions and acute complications.
  - The study found that overall cost among 654,673 patients hospitalized with COVID-19 was \$16.2 billion between March 2020 and July 2021.
  - Estimated per-patient hospitalization cost was \$24,826.
  - Among surviving patients, estimated per-patient cost was \$13,090 without ICU admission or IMV, \$21,222 with ICU admission alone, and \$59,742 with IMV.
  - The estimated cost among patients who died was \$27,017 per-patient and costs ticked higher for patients with underlying medical conditions and acute complications.

Given the importance of ongoing evidence generation for new infectious diseases, variants, patterns of infection, vaccine and booster efficacy, impacts on health outcomes, antimicrobial resistance, costs and healthcare resource utilization (HRU), **Premier urges Congress to continue CDC's ability to conduct robust research utilizing private sector healthcare data sets.** Such information may allow researchers and clinicians to analyze surges, allowing communities and health systems to prepare with appropriate staffing, personal protective equipment (PPE) supplies, treatment options and access to care.

## X. CONCLUSION

In closing, Premier applauds your commitment to improve the nation's public health response capabilities for emergencies. Premier looks forward to working with Congress to further refine the capabilities and authorities of the CDC and develop a cohesive and holistic national strategy for addressing global pandemics.

If you have any questions regarding our comments or need more information, please feel free to contact me at [soumi\\_saha@premierinc.com](mailto:soumi_saha@premierinc.com) or 732-266-5472.

Sincerely,



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