

To: Committee on Ways & Means Rural and Underserved Communities Task Force
From: American Medical Association
Date: November 27, 2019
Re: Request for Information on Priority Topics Affecting Health Status and Outcomes

The American Medical Association (AMA) is pleased to provide the following responses to the Committee on Ways & Means Rural and Underserved Communities Task Force request for information on priority topics affecting health status and outcomes.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

The myriad of factors facing rural and medically under-served urban areas are uniquely challenging. Geographic differences aside, vast rural areas, and densely populated, yet under-resourced urban environments both disproportionately struggle to care for the sickest of patients; experience a dearth of primary healthcare professionals; and endure strenuous, disruptive financial burdens. Moreover, the impact of surging hospital closures in medically underserved rural and urban areas detrimentally impacts overall patient well-being. About 2,000 of the nation's acute care hospitals are located in rural areas; 161 rural hospital closures have occurred between January 2005-2019.¹ These structural barriers to health care and access are exacerbated by deepening shortages of medical professionals and providers that are not easily resolved through increased coverage and payment of health services. Instead, they require structural investments in connectivity.

Rural health outcomes are also impacted by greater obesity and disease burden in children and adults, higher mortality rates, and shorter life expectancy compared to urban areas. These "red zones", wherein life expectancy is on the decline, also have fewer employment and education opportunities, which are risk factors for poor health outcomes and can undermine population health.

These issues, however, are not confined to rural areas. Although often associated with greater resources and higher concentration of healthcare facilities, urban areas also face daunting social and systemic issues, such as lack of access to comprehensive transportation; childcare services during ideal medical appointment times; and healthcare navigation support systems. Greater access to these types of services would engender medical institutional trust and, ostensibly, regular engagement with healthcare professionals, which is associated with better health outcomes across populations, across the life course. Given that research shows almost 80 percent

¹ [1] <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> Accessed November 25, 2019

of health influences originate outside clinical settings, intentionally and innovatively creating and implementing policies that support equitable health outcomes is paramount to our nation's health.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Payment and coverage for technology-enabled services can provide clear and demonstrable benefits to patient health outcomes, reduce disease burden, and lower costs in rural and underserved communities. The AMA has compiled evidence and advocated strenuously for federal health care program coverage for a range of digital medicine services, including telehealth, remote patient monitoring and management, and e-consults between treating physicians and specialists. Health systems using digital medicine can increase access to rural communities, as well as safety net providers, in order to improve outcomes by supporting adherence through reduced transportation costs that are an additional impediment to accessing health care. The AMA strongly urges passage of H.R. 4932 / S. 2741 (CONNECT for Health Act), which would lift the most significant impediment to telehealth for both rural and other underserved Medicare beneficiaries. Namely, the current Medicare program has antiquated statutory restrictions that prohibit telehealth services in a beneficiary's home, with a few exceptions, and primarily limit services to a very limited number of rural communities. H.R. 4932 would increase the discretion of the Centers for Medicare and Medicaid Services (CMS) to issue waivers on these statutory limitations. Also, it would ensure the limitations are lifted outright for all Medicare beneficiaries who require mental health and emergency services, as well as Medicare beneficiaries receiving services in rural health clinics, federally qualified health centers, and Indian health services. The AMA also urges increased broadband and wireless for rural providers to ensure the full array of services can be offered.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Increasing coverage and payment for health care services utilizing a range of digital health modalities that are clinically validated and integrated into the continuum of services provided by rural providers is essential to ensuring that rural patients retain access to in-person services, as well as a full array of health care services that can be offered virtually. The AMA supports lifting restrictions on coverage and payment for telehealth services through passage of H.R. 4932 / S. 2741 (CONNECT for Health Act), but with the clear provision that patient choice for selection of services should be optimized to ensure care is available both in-person and virtually. Virtual services should increase volume adequacy so long as done in a manner that encourages care coordination and continuity of care with medical homes and existing community providers. Outside of traditional Medicare, this should result in other payers, including Medicare Advantage plan sponsors, increasing coverage of virtual services, but without restricting access to in-person services by allowing virtual services to be included as part of network adequacy. There remains a

full range of medical services that cannot be offered virtually and lack the necessary evidence base to be completed via digital health. Allowing these services to be provided virtually would lead to poor outcomes and potentially higher costs. Thus, the AMA has leveraged the expertise of our Digital Medicine Payment Advisory Group to identify virtual services that advance the quadruple aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations, reducing the per capita cost of health care, and improving the experience for physicians and the health care team.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

- a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?**
- b. there is broader investment in primary care or public health?**
- c. the cause is related to a lack of flexibility in health care delivery or payment?**

In the smallest and most isolated communities, the rural hospital will be the only source of health care services available, so elimination of a hospital service line will usually mean that the community will simply not have the service at all. Indeed, many small rural communities only have access to primary care because the Critical Access Hospital operates a Rural Health Clinic and standard payments for primary care services are too low to support a primary care practice in a rural community. Most rural communities would like to make greater investments in primary care, behavioral health, and other services. However, services cannot be expanded simply by granting greater flexibility in the use of current payments when those payments are not even sufficient to support the essential services a community is trying to deliver today. In many communities, low payments from Medicare and other payers for the Rural Health Clinic services is a major contributor to the financial losses at the hospital and if these losses are not reversed, the community could lose both primary care and hospital services. One important way to provide more adequate payment for rural health services would be to reduce the unreasonably high minimum visit requirement for physicians working in Rural Health Clinics that is used to calculate payment rates.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

The [OCHIN Collaborative](#) and the California Telehealth Network (CTN) provide an integrated set of digital health and health information technology tools to a range of providers across the nation that focus on rural and other underserved communities. The OCHIN Collaborative provides services to community health centers, Federally Qualified Health Centers, and rural health clinics. In 2017, the OCHIN Collaborative acquired the CTN to further increase access for rural and frontier communities as well as other underserved patients. The OCHIN Collaborative's [success](#) has been a combination of “state-of-the art solutions” with a “focus on

low-income, vulnerable, and underserved patients” in order to advance health equity and high-quality health care. However, scaling and access are stymied by the Medicare restrictions on telehealth that could be remedied by H.R. 4932 / S. 2741 (CONNECT for Health Act) and addressing the lack of federal investment in widespread wireless and broadband connectivity. The foregoing barriers are particularly burdensome for the most vulnerable communities in rural and urban areas. Passage of H.R. 4932 would provide an alignment of incentives that would allow transformation and optimization of healthcare in the communities the OCHIN Collaborative and CTN serve, as well as the many other physician practices around the nation providing care in safety net communities. Another example is detailed below, Project ECHO, that ensures the providers in underserved and remote communities are able to access resources and clinical information to improve their patients’ health care outcomes.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

There are several successful models which demonstrate a positive impact on addressing workforce shortages in rural/underserved areas:

- Launched in 2013 by the AMA, the Accelerating Change in Medical Education ([ACE](#)) initiative established and continues to foster a community of innovation and discovery by supporting the development and scaling of creative undergraduate medical education (UME) models across the country. Building on its work to accelerate change in UME, the AMA recently established the [Reimagining Residency initiative](#)—a new five-year, \$15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training.
- Conrad 30 Waiver Program: The Conrad 30 Waiver program allows J-1 medical doctors to apply for a waiver for the two-year residence requirement upon completion of the J-1 exchange visitor program. The program addresses the shortage of qualified doctors in medically underserved areas. See support letter for [H.R. 2895](#), the “Conrad State 30 and Physician Access Reauthorization Act.”
- Increase GME slots by removing the GME cap established in the Balanced Budget Act of 1997, funding the expansion of GME slots, or allowing for cap-flexibility.
- [Project ECHO](#) (Extension of Community Health Outcomes): Using proven adult learning techniques and interactive video technology, the ECHO Model™ connects groups of community providers with specialists at centers of excellence in regular real-time collaborative sessions.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

With respect to treatment for opioid use disorder and other substance use disorders, there are several promising efforts underway in states. This includes:

- Colorado law that supports increased, evidence-based resources for treatment that has led to significant reductions in opioid-related overdose in counties using the state grants. Services have included screening and treatment for behavioral, mental, and substance use disorders.
- In Pennsylvania, the state has supported Centers of Excellence that are specifically designed to get more people into treatment and keep them engaged in their care. The centers coordinate care for people with Medicaid, and treatment is team-based and “whole person” focused, with the explicit goal of integrating behavioral health and primary care.
- North Carolina’s Project OBOT (Office Based Opioid Treatment) is a community-focused collaborative care effort that provides training to health care professionals and others, coordinates care within the community, uses telemedicine and other technology to increase patient engagement, and streamlines appointments and scheduling to help reduce transportation and other potential barriers.
- Mobile methadone vans have been able to serve hundreds of persons with opioid use disorder in multiple states—reducing the burdens of daily travel to receive medication. Expansion of this type of program, however, has been delayed due to DEA not approving new vans delivering methadone maintenance therapy for more than 10 years.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Unfortunately, while the availability of post-acute care and long-term care continues to constrict, there are few examples of scalable services for these settings improving health outcomes and reducing isolation, particularly in rural and underserved communities. Instead, there is significant promise to offering telehealth and other digital modalities in post-acute and long-term care settings; yet, lack of coverage by Medicare, Medicaid, and commercial payers reduces access to these essential services that would allow for scale. Rehabilitation and long-term care facilities rarely have physicians on staff 24-hours a day, seven days a week and lack access to specialty care onsite. As a result, when such care is needed, a patient may be transmitted to an emergency department for care or an alternative site of care. The transfer trauma, complications to care coordination and continuity of care, along with the exposure to infection increase exponentially. Research suggests about two-thirds of hospital admissions from nursing homes were potentially

avoidable.² And, the costs could have also been avoided as well as the risk to overall patient health status. Providing health care outside of a hospital will not only lower overall costs, but will also ensure continuity of care and enhanced care coordination. Removing Medicare payment and coverage restrictions on telehealth present the most significant solution to scaling access and the quadruple aim.

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

Application of an equity lens is elemental to data solutions to hard health care issues in medically underserved areas. Big data in health care are promising. Nevertheless, big data that account for—not control for—*avoidable*, historical health differences along racial, gender, socioeconomic, language, and geographic lines, and so forth, would transform clinical decision making and ultimately lead to better patient health outcomes. Broadly, the AMA advocates for data intelligence and technological supports for physicians that boost patients' care experiences and health outcomes; improve population health; and reduce health care costs while also increasing health care value and enhancing health care teams' professional satisfaction. Historically, medically underserved communities, such as those who live in rural and urban under-resourced areas, are often bereft of high-tech, data-driven population health care. Thus, the AMA supports health data integration that addresses and redresses biases, which exacerbate avoidable health care disparities. Also, without equity mindfulness embedded into the design of data algorithms, the peril of data application in health care is the persistence of biases in diagnoses and medical treatment. To date, the health care field lacks interoperability of data systems, and there is no standard collection procedure for demographic data that would augment physicians' clinical decision making. Unfortunately, the data systems that do exist have used poor proxies to predict patients' health status, have excluded certain populations from study samples, or neglect to test data systems within private as well as safety net hospitals, which are rife in rural and urban under-resourced settings.

The AMA convened its Integrated Health Model Initiative (IHMI) to begin addressing these issues. For example, it is working on the creation of nearly two dozen new ICD-10 codes related to SDOH, which could trigger referrals to social and government services to address people's unique needs. The AMA's IHMI group's ongoing work focuses on market-driven needs in health care data interoperability through the development of common data portability standards that enhance information sharing and unlock potential improvements in patient outcomes.

² [1] <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1532-5415.2010.02768.x>

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

The AMA strongly urges Congress to take action to expand access to digital health modalities including telehealth through passage of H.R. 4932 / S. 2741 (CONNECT for Health Act) as the most direct and impactful way to expand access to underserved communities including those in rural areas. Restructuring health care delivery in a physician practice and other practices does not occur overnight and requires planning and resources and this is all the more true for providers who are providing medical services to underserved communities where resources are limited and often insufficient for even direct, immediate clinical care. The AMA has developed [resources to facilitate adoption](#), but most providers are not able to include telehealth in these re-design efforts due to Medicare's restrictions. While the AMA has successfully advocated along with representatives of major health systems, physician organizations, innovators, and other digital health associations to expand coverage for remote patient monitoring and e-consults based on existing CMS authorities, the current statutory limitations on telehealth continue to dampen adoption overall. In order to realize the full benefit of care delivery re-design in an integrated manner that reduces the burden of adoption and allows for scale, telehealth coverage is essential and congressional action to pass H.R. 4932 is needed. Also, we support increased financial incentives for physicians practicing in rural and urban underserved areas, including scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, and especially in primary care.

Should you have any questions, please do not hesitate to contact either Chris Sherin (Christopher.Sherin@ama-assn.org; 202-789-7432) or Andrew Wankum (Andrew.Wankum@ama-assn.org; 202-789-7458) with the American Medical Association.