AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(N-21)

Introduced by: Iowa

Subject: Recognizing and Remedying "Structural Urbanism" Bias as a Factor in Rural Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Rural Americans' health disparities are significant and unacceptable, with mortality rates 23% higher, and preventable hospitalizations 40% higher-- across all racial and age groups; and

Whereas, The differences in rural vs. urban health measures have been worsening over the last 30 years; and

Whereas, The percent of physicians who practice in rural areas is about 11%, despite 20% of Americans living in rural America; and

Whereas, Health care research (Johnston, et al.[1]) has shown that the biggest reason for worse rural mortality and preventable hospitalization rates is the shortage in "local-area supply of specialists, which explained 55% of the differences in hospitalization rates and 40% of the difference in mortality rates"; and

Whereas, Medicare's physician geographic payment policy since 1992 (developed under the direction of consultants from the Urban Institute) has chronically discriminated against rural physicians, with the current policy adjusting rural physician E&M payments as much as 25-30% lower than some urban areas, and adjusting rural diagnostic testing payments 50-60% lower than some urban areas; and

Whereas, Another research group (Probst, et al.[2]) wrote that "rural health disparities are due in part to declining healthcare provider availability and accessibility in rural communities" and "these problems are exacerbated by structural urbanism" ... a bias which "systematically shortchanges rural areas". They also suggested that "current models of health care funding... are innately biased in favor of large populations" and "until this bias is recognized, the development of viable models of care across the rural-urban continuum cannot move forward"; and

Whereas, In the CME report on Rural Health Physician Workforce Disparities, telehealth was touted as one way to remedy rural health disparities, and the CME recognized some of the telehealth barriers such as the current site of service Medicare payments. The problem is that without geographic equity in telehealth payments there would be no financial incentive for urban physicians to serve rural vs. urban patients, and keeping Medicare's geographically adjusted payments unchanged would give incentives for rural physicians to receive higher telehealth payment for urban patients; and

Whereas, national telehealth services who serve rural and urban hospitals and physician groups do not give geographic discounts for their services, which means there is a national, not a local, "market price" for teleservices, unlike Medicare's geographic payment policy which shortchanges rural physicians; therefore be it

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called "Structural Urbanism," has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America's health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

Fiscal note: not yet determined

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the identification and remediation of health disparities, and this resolution asks for action to help address a major, unacceptable disparity in health care access and outcomes, with identification of causes for the 23% higher mortality and 40% higher preventable hospitalizations that could impact 60 million rural Americans.
The resolution is also timely because the COVID-19 pandemic has highlighted the need for telehealth legislation to help improve access to care to all Americans, especially underserved rural residents. The telehealth resolution would ensure that increased access, which telehealth legislation would bring, is not a hollow promise.

References:
1. Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
2. Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Geographic Practice Cost Index D-400.985
Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.
Citation: (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12; Reaffirmation: I-12; Reaffirmation I-13)

Elimination of Payment Differentials Between Urban and Rural Medical Care H-240.971
Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.
Citation: Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Equal Pay for Equal Work D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.
Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Improving Rural Health H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

Access to and Quality of Rural Health Care H-465.997
(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.
Citation: CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

Enhancing Rural Physician Practices H-465.981
The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
Citation: CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and

Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.
Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19

Rural Health H-465.982
The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.
Citation: (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Economic Viability of Rural Sole Community Hospitals H-465.979
Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.
Citation: (CMS Rep. 3, A-15)

Closing of Small Rural Hospitals H-465.990
Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.
Citation: (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10: Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)