STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on Ways and Means
Subcommittee on Health

Re: Bridging Health Equity Gaps for People with Disabilities and Chronic Conditions

February 3, 2022

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Ways and Means Subcommittee on Health as part of the hearing entitled, "Bridging Health Equity Gaps for People with Disabilities and Chronic Conditions." The AMA commends the Subcommittee for focusing on this critically important issue. The AMA recognizes racial and ethnic health inequities as a major public health problem in the U.S. and as a barrier to effective medical diagnosis and treatment, especially for people with disabilities and chronic conditions. The elimination of racial and ethnic inequities in health care is an issue of highest priority for the AMA, and we advocate that health equity—defined as optimal health for all—be a goal for the U.S. health system. In order to address social determinants of health (SDOH)[1] and health inequities, the AMA has created a Center for Health Equity whose mission is to strengthen, amplify, and sustain the AMA's work to eliminate health inequities—improving health outcomes and closing disparity gaps—which are rooted in historical and contemporary injustices and discrimination.

SDOHs greatly impact patients with disabilities and chronic conditions, as well as health equity, in general. Yet, the SDOHs are affected by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In this country, these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and, therefore, affect health itself. These larger, powerful systems of racism and gender oppression—also known as the root cause inequities—are upstream to the social determinants of health. They have shaped the social conditions in which people live, and they work to produce inequities across society in complex ways.

SDOH Challenges

The AMA is strongly committed to improving health equity, health outcomes, SDOH, and decreasing health disparities for all Americans, especially those with disabilities and chronic conditions. Because SDOH can significantly and adversely impact an individual's health, physicians are increasingly collecting data on their patient population by screening for individual social risks and working with their patients to address identified social needs, as well as understanding how these factors impact the

[1] According to Healthy People 2030, the "social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk."[1] These social determinants include education, housing, wealth, income, and employment. We all experience conditions that socially determine our health or the SDOH. However, we do not all experience them equally.

community, at large.[2] According to a study published in Journal of the American Medical Association, approximately 24 percent of hospitals and 16 percent of physician practices reported screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence.[3] When researchers asked about barriers to screening, practices and hospitals primarily reported that the lack of screening was attributed to insufficient financial resources, time, and incentives.

Addressing SDOH and Health Inequities

The AMA acknowledges that enjoyment of the highest attainable standard of health, in all its dimensions, is of paramount importance, and that the provision of health care services, as well as optimizing a patient's interactions with the SDOH, are ethical obligations of a civil society.

The AMA recognizes the 15 competencies of lifestyle medicine as defined by a blue-ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010.[4] The fifteen competencies fall within the broader categories of leadership, knowledge, assessment skills, management skills, and use of office and community support. The AMA continues to urge physicians to acquire and apply the fifteen clinical competencies of lifestyle medicine and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine. In addition, the AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

The AMA also strongly supports efforts designed to integrate training in SDOH, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients, including those with disabilities and chronic diseases, safe, high-quality and patient-centered care. The AMA also supports faculty development, particularly clinical faculty development, by medical schools to assure that they provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of SDOH.

Yet, a clear gap exists in the availability of simple basic needs such as housing, safe drinking water, access to healthy foods and places to be physically active. As a result, the AMA, in collaboration with other health care and community-based organizations, is working to identify and eliminate the structural and social barriers that contribute to chronic diseases. In particular, the AMA continues to work to address SDOH, especially for those with chronic diseases, through the promotion of diabetes prevention and lowering overall rates of hypertension, as well as our ongoing work to mitigate various other risk factors, such as obesity, that can lead to improved health outcomes.

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[2] For clarity, an individual-level "social risk" refers to "attribute or exposure of an individual that increases their likelihood of poor health," whereas an individual-level "social need" refers to an individual's expressed priorities and preferences. For example, a social risk screening tool may identify that an individual has unstable housing, a lack of access to healthy food, and low income; however, that individual may tell her physician that the lack of housing is her most pressing need to address. See Alderwick H, Gottlieb LM, Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems, Millbank Quarterly, Dec. 2021, https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/.

[3] Fraze TK, Brewster AL, Lewis VA, Beidler LB, Murray GF, Colla CH. Prevalence of Screening for Food Insecurity, Housing Instability, Utility Needs, Transportation Needs, and Interpersonal Violence by US Physician Practices and Hospitals. JAMA Netw Open. 2019;2(9):e1911514. doi:10.1001/jamanetworkopen.2019.11514.

[4] Lianov L, Johnson M. Physician competencies for prescribing lifestyle medicine. JAMA. 2010 Jul 14;304(2):202-3. doi: 10.1001/jama.2010.903. PMID: 20628134.

In fact, the AMA has been working to establish clinical systems that identify patients at risk for diabetes along with referral processes to programs or interventions available in health care settings or the local community. Where we have seen the greatest success in addressing SDOH is in those health systems that use programs like Aunt Bertha's and One Degree, which are clearinghouses of programs and services that are integrated into clinical workflows, thus making it simple to find, refer, and track access to resources for patients.[5, 6] The AMA remains committed to supporting and funding programs that establish more of these clearinghouses and infrastructure support programs so they can be embedded anywhere health care services are delivered.

It is important to note that Congress is also pursuing bipartisan solutions to the dual issues of reducing and preventing diabetes and obesity among Americans. More specifically, the AMA supports H.R. 2807/S. 2173, "the Promoting Responsible and Effective Virtual Experiences through Novel Technology to Deliver Improved Access and Better Engagement with Tested and Evidence-Based Strategies (PREVENT DIABETES) Act." bipartisan legislation designed to increase access to the Medicare Diabetes Prevention Program Expanded Model (MDPP). The MDPP is a structured intervention designed to help patients at high risk of developing Type 2 diabetes avoid such diagnoses via classroom-style training in long-term dietary change, increased physical activity, and behavioral changes to promote weight control. The program features a minimum of 16 intensive "core" sessions covering a Centers for Disease Control and Prevention (CDC) curriculum taken over 6 months, followed by less intensive monthly follow-up meetings. The goal is for MDPP participants to achieve at least 5 percent weight loss. To help foster greater patient access, H.R. 2807/S. 2173 allows CDC recognized virtual suppliers to participate in the MDPP.

In addition, the AMA recommends that the MDPP Expanded Model Flexibilities, allowing patients to receive these services virtually be made permanent. CMS, via the 2021 Medicare Physician Fee Schedule Rulemaking process, adopted these important flexibilities for the duration of the COVID-19 PHE and in future 1135 waiver emergencies to address the disruption to in-person MDPP services during the pandemic. Yet, these flexibilities will only apply in emergency situations rather than on an ongoing basis. The reality is that MDPP services are being significantly underutilized and if the MDPP flexibilities put in effect for the COVID-19 PHE and future emergencies are permanently instituted, it would significantly strengthen the effectiveness of diabetes prevention services for Medicare patients with prediabetes. As stated above, the AMA strongly urges Congress to pass H.R. 2807/S. 2173, "The Prevent Diabetes Act."

The AMA is also pleased to support H.R. 1577/S. 596, "the Treat and Reduce Obesity Act." Medicare now covers "intensive behavioral therapy for obesity" at no cost to the beneficiary if the therapy is furnished by a physician in primary care or other defined specialty, or by a certain non-physician, and takes place in a physician's office, a hospital outpatient department, or in an independent or public health clinic.

H.R. 1577 would allow Medicare to pay a physician who is not in primary care for providing this therapy in any appropriate setting, including community-based sites. The legislation would permit payment for non-physician providers if they have a referral from a physician or primary care practitioner and work in collaboration and coordination with them. The legislation also requires Medicare Part D plans to cover drugs that treat obesity or support weight loss management for individuals who are overweight. Swift Congressional enactment of this legislation will certainly help patients with chronic conditions, many of which are caused by or exacerbated by obesity.

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[5] https://company.auntbertha.com/.
[6] https://www.1degree.org/.

Other federal policies and strategies that further strengthen efforts to address SDOH include (but are not limited to): Removing barriers to access health insurance coverage and care (including expanding access to insurance subsidies to promote purchasing of health insurance coverage offered on the Affordable Care Act exchanges and the expansion of Medicaid); directing the Centers for Medicare and Medicaid Services (CMS) to incorporate SDOH data and provide support for addressing patients' SDOH in Medicare and Medicaid payment systems and alternative payment models; funding efforts to address SDOH along with identifying and overcoming existing barriers to implementing SDOH-related programs; and increasing funding to community-based organizations to strengthen infrastructure and capacity to coordinate and collaborate with patients and health care organizations.

Yet, a system-level gap that also serves as a main barrier to addressing SDOH and bridging the health equity gap for people with disabilities and chronic conditions is an insufficient financing or physician payment structure. **Congress must ensure that payments are adequate in traditional fee-for-service systems, capitation, and value-based payment models to support physicians taking into account and addressing their patients' SDOH by, for example, compensating practices for identifying and coordinating provision of appropriate non-medical support services for their patients.**

Finally, Congress is also working to assuage the broader impact of SDOH on patient care and **the AMA supports two crucial pieces of bipartisan legislation that offer federal solutions to address these non-health care factors, specifically H.R. 2503, "the Social Determinants Accelerator Act of 2021," and H.R.6072/S. 509, "the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act."**[7, 8] Although pleased to support this bill that requires the HHS Secretary to award grants to states, on a competitive basis, to support the establishment of new or enhancement of existing community integration network infrastructure to connect health providers to social services organizations, the AMA is currently working with the lead sponsors of H.R. 6072 to ensure that patient privacy is also properly protected. The AMA urges federal lawmakers to pass both the Social Determinants Accelerator Act and the LINC to Address Social Needs Act into law during the 117th Congress.

Addressing Behavioral Health and Substance Use Disorders

One of the policies that is critical to addressing inequities, particularly with regard to individuals with behavioral health needs, is the Medicaid Reentry Act of 2021, S. 285 (Baldwin, D-IL/Braun, R-IN) and H.R. 955 (Tonko, D-NY/Turner, R-OH). The Medicaid Reentry Act would allow Medicaid to cover health services—including physical, mental health, and care for substance use disorders — in the last 30 days of incarceration for people who meet Medicaid eligibility criteria. This would help connect people to the care they need as they return to their communities. The Medicaid Reentry Act would save lives, reduce drug overdoses, advance equity, save money, and increase reentry success. The AMA and more than 100 groups across the country from local and state government, health care, criminal legal system reform, law enforcement, faith, reentry, substance use disorders (SUDs), and mental health constituencies support this lifesaving policy and urge its passage by Congress.

At a threshold level, there also needs to be transparency and accountability about substance use disorder and mental health networks. The AMA has consistently advocated for departments of insurance and other stakeholders to require payers to provide accurate, timely information about who in an enrollee's

[7] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-4-AMA-Letter-to-House-re-Support-for-HR-2503-Social-Determinants-Accelerator-Act-v2.pdf.
[8] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Letter-to-Sullivan-and-Murphy-re-Leveraging-Integrated-Networks-in-Communities.pdf.

network is accepting new patients. The AMA has pursued this type of action due to the fact that as patients routinely report an inability to access evidence-based care for mental health, an opioid use disorder or other SUDs. The reasons include wide disparities in access to in-network care; prior authorization and other utilization management hurdles both for providers and medication; difficulties in determining which in-network providers are accepting new patients; and cost-sharing decisions that may place some medications or other treatments out of reach. These disparities often fall hardest on historically marginalized and minoritized populations. **To help address this, the AMA urges actions such as those being pursued by the Colorado Division of Insurance.**

Telehealth and Increased Broadband Access Helps Bridge Care Gap for Patients with Chronic Conditions and Underserved Communities

Access to telehealth services can help reduce care inequalities, especially for patients living in underserved communities or afflicted with chronic conditions, by providing access to services regardless of where individuals are located. In conjunction with expanded access to telehealth services, the AMA supports Congressional efforts to expand high-speed broadband internet access to underserved communities and increase digital literacy education efforts.

Access to Telehealth Services

Technology can undoubtedly play a unique role in alleviating the negative impact of SDOH on patient outcomes. Yet, existing statutory limitations on access to telehealth services for Medicare beneficiaries, specifically the geographic and originating site restrictions, is a key federal policy that presents major challenges for physicians committed to addressing SDOH.

Under section 1834(m) of the Social Security Act (SSA), Medicare is prohibited from covering and paying for telehealth services delivered via two-way audio-visual technology unless care is provided at an eligible site in a rural area. This means that, in order to access telehealth services, patients must live in an eligible rural location, and must also travel to an eligible "originating site"—a qualified health care facility—to receive telehealth services, except in the few cases where Congress has authorized provision of telehealth services in the home of an individual. As a result, the section 1834(m) restrictions bar the majority of Medicare beneficiaries from using widely available two-way audio-visual technologies to access covered telehealth services unless they live in a rural area, and with a few exceptions, even those in rural areas must travel to an eligible health care site.

Two-way audio-visual technology is the only communication modality on which Medicare places such a prohibition. Other communication technologies, including remote patient monitoring, do not meet the definition of a telehealth technology and services furnished via these technologies are not subject to the section 1834(m) geographic and originating site restrictions and go through regular Medicare coverage and payment processes. While these restrictions may have made sense given the limited technologies available when they were first instituted in the Balanced Budget Act of 1997, two-way audio-visual technology is now much more widely available and less expensive.

In response to the COVID-19 public health emergency (PHE), Congress passed the CARES Act, which, among other things, provided CMS the authority to waive the geographic origination requirement for the duration of the COVID-19 PHE, which CMS subsequently did. The AMA remains deeply grateful for these flexibilities, which have allowed Medicare patients across the country to receive care from their homes. However, without further legislative action from Congress, Americans that have come to rely on telehealth services during the PHE will abruptly lose access to these services completely. As a result, Congress must act now to remove the origination and geographic restrictions on telehealth coverage for Medicare patients. Continued access to telehealth services beyond the PHE is critical for patient

populations that have come to rely on its availability. **In particular, the AMA supports S. 368/H.R. 1332, the "Telehealth Modernization Act of 2021," which would eliminate the 1834(m) statutory restrictions on originating sites and geographic locations, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located.** It is crucially important, in the context of alleviating SDOH and providing care to people with disabilities and chronic conditions, that Medicare beneficiaries continue to be able to access telehealth services from their physicians without arbitrary restrictions throughout the COVID-19 public health emergency and beyond.

Physician practices are ready to invest in the technology required to provide these services; however, it will be very difficult to provide the sustained financial commitment needed to incorporate delivery of telehealth services into their workflows if the coverage is only temporary. **While CMS has expanded coverage of telehealth services during the PHE, only Congress can assure all Medicare beneficiaries can receive equal access to those services moving forward. Delaying action, such as extending the current section 1834(m) waiver authority, will only increase the cost of making this necessary and overdue policy change.**

Increasing Broadband Internet Access

Lack of access to broadband and/or audio-visual capable devices is another major impediment to receiving high quality technology-enabled care for many Americans, including seniors in minoritized and marginalized communities where there were significant health disparities before COVID-19 that have become much worse during the pandemic. For example, according to the Federal Communications Commission, 628,000 tribal households lack access to standard broadband. Based on data from 14 participating states, the Centers for Disease Control and Prevention (CDC) reported that age-adjusted COVID-19–associated mortality among American Indian and Alaska Native persons was 1.8 times that among non-Hispanic Whites.[9] Likewise, in an October 2020 article Government Technology reported that less than half the population in certain parts of Alabama, which are minoritized communities, have internet access, and two of these Alabama counties have no internet access at all.[10] Marginalized urban communities have also been excluded from broadband service and need to rely on audio-only visits, because even when cities have broadband, many residents of these communities do not have access to it in their homes. A June 2020 report of the National Digital Inclusion Alliance describes data showing that the U.S. has more than three times as many urban as rural households living without home broadband of any kind.[11]

The AMA recognizes access to broadband internet as a SDOH and we believe it is vitally important to continue and broaden efforts to provide broadband internet access to all Americans. Ensuring access to broadband access and two-way audio-visual technologies would have a tremendous impact on alleviating challenges to access of digital health technology. The AMA applauds Congress for including $65 billion in the Infrastructure Investment and Jobs Act, commonly referred to as the Bipartisan Infrastructure Deal, enacted into law in 2021. These resources are an important start to ensuring that every American gains access to reliable high-speed internet and we urge federal lawmakers to further bolster this investment. In addition, initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations would help ensure that these communities can effectively use digital health tools once they have access to them. **The AMA also supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.**

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9 https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm.
10 https://www.govtech.com/network/pandemic-worsens-internet-disparity-in-alabama-black-belt.html.
11 https://www.digitalinclusion.org/digital-divide-and-systemic-racism/.

Best Practices and Opportunities to Further Address Health Inequities

The Drug Enforcement Administration (DEA) adopted special flexibilities for the treatment of patients with opioid use disorder (OUD) and for controlled substance prescriptions. During the PHE, physicians have been able to start and maintain patients on buprenorphine to treat OUD based on telehealth and audio-only visits. Physicians can also prescribe controlled substances based on telehealth visits. It is also extremely helpful for patients receiving methadone to be able to get take-home supplies. **Surveys in which the AMA has participated have found that all the flexibility provided by the DEA has been extremely helpful to patients and physicians and we recommend maintaining them after the PHE.**[12]

Transformative Actions

The AMA believes that CMS needs to provide adequate resources to help physician practices achieve better health outcomes for high-risk patient populations. For example, in the Medicare program, all patients with Medicare coverage do not have equal opportunities to achieve good health outcomes, so one-size-fits-all models are more likely to widen than reduce disparities. Payments within alternative payment models and performance measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. Payment methodologies should also be designed to support and encourage practices to address patients' social needs, including by providing care management services and coordinating services across interprofessional teams.

Start-up funding should also be provided to participants in alternative payment models so they can invest in data analytic capabilities, care managers, training, and other practice changes needed to improve care delivery and facilitate successful participation. Physician practices, particularly small and rural practices and those serving historically marginalized and minoritized patients, do not have financial reserves available to fund practice changes in advance of shared savings payments or to pay large penalties to CMS and other payers if their patients have greater SDOH and medical needs than can be supported by payment models.

Efforts need to be made to ensure that communities with greater SDOH needs are included in alternative payment models. For example, CMS primary care medical home models are now in their fourth iteration, but they still are not available in many states, including Alabama, Mississippi, and most states in the southeastern and southwestern US.

The AMA strongly urges Congress to properly fund the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) at $153 million for its Social Determinants of Health program – in line with President Biden's Fiscal Year 2022 request.[13] We ask Congress to build upon their initial investment to ensure that public health departments, academic institutions, and nonprofit organizations are properly supported to address the SDOH in their communities.

Conclusion

The pursuit of health equity is a pathway towards excellence in our health care system, one that ensures the valuing of human experience and rights. It is one that recognizes that we must do more as institutions to protect individuals and families. It will take all of us working in partnership—and the AMA is

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[12] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-11-20-Letter-to-McDermott-re-DEA-Telehealth-Flexibility.pdf.

[13] https://www.tfah.org/wp-content/uploads/2021/04/CDC_SDOHFunding_SignOn.pdf.

committed to doing so—to build and continue on a path forward to advance health equity. We look forward to continuing to work with the Committee to advance these shared goals.