

November 29, 2019

The Honorable Richard E. Neal
Chairman
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady,

The American Society of Anesthesiologists (ASA), on behalf of its 53,000 members, appreciates the opportunity to provide feedback on the [Request for Information](#) (RFI) soliciting input on priority topics that affect health status and outcomes. We support the goals of the Rural and Underserved Communities Health Task Force and the effort to tackle these important issues facing rural and underserved communities by the Ways and Means Committee.

The ASA is pleased to share its feedback on the following question presented in the RFI:

Q10. 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?

Extend the Medicare pass through to allow rural hospitals to recruit and retain physician anesthesiologists. Many states face ongoing challenges in assuring access to medical care services for their citizens living in rural areas. Insufficient Medicare payments and low patient volume have made it particularly difficult for many rural facilities to attract and retain qualified health care providers. Congress created the rural “pass-through” program as an incentive for anesthesia providers to practice in Critical Access Hospitals (CAHs) and small, rural hospitals. Under the pass-through program, eligible hospitals may use reasonable cost-based Part A funds in lieu of the conventional Part B fee schedule to induce anesthesia providers, such as nurse anesthetists and anesthesiologist assistants, to provide anesthesia services in CAHs and small, rural hospitals. Currently, there are 548 eligible hospitals across 38 states. When there is already an acknowledged shortfall of physician health care providers, particularly in rural communities, it is essential for hospitals to have flexible policies that help facilitate increased access to necessary providers. Under the Centers for Medicare and Medicaid Services (CMS) interpretation of the current “pass-through” program, eligible small rural hospitals are not permitted to use the “pass-through” funds to hire physician anesthesiologists. Changes are necessary to expand rural access to include the services of physician anesthesiologists. This change will allow eligible hospitals to expand the complexity of their surgical offerings; keeping patients close to their families, reduce transportation costs and unnecessary time away from employment.

ASA recommends that the Medicare Access to Rural Anesthesiology Act of 2019 (H.R. 2666), introduced by Representatives Emanuel Cleaver (D-MO) and Jason Smith (R-MO), be enacted. The bill would reform the current Medicare rural incentive program to include physician anesthesiologists. In short, this bill would enable hospitals to implement the proven anesthesia care team model by adding physician anesthesiologists to the care team and to provide a full range of physician-led services to patients in rural and underserved areas. Provisions of this bill were previously included in Ranking Member Brady’s “Hospital Improvements for Payment Act of 2014”.

Rescind Centers for Medicare and Medicaid Services (CMS) regulations that diminish patient safety and the quality of care in health systems that provide care to rural communities. CMS Conditions of Participation 'opt-out' provisions allow a governor to exempt one or more hospitals in the state from the federal requirement for physician supervision of nurse anesthetists. The unintended consequence of this policy is that in those states that have exercised an opt-out, the rural hospitals, typically the most under-resourced and institutionally fragile hospitals in any state, now have less physician engagement and oversight of anesthesia care. The opt-out provisions are an unnecessary disservice to rural patients and are likely harmful to patients undergoing surgery and anesthesia in these already under-resourced facilities.

The rescission of this ill-advised regulation will strengthen rural hospitals. For example, Texas, the state reportedly with the most rural hospital closures in the United States, is also the state with the highest maternal morbidity/mortality where a greater percentage occurs in the state's rural hospitals. Where the care of physician anesthesiologists is provided in some of Texas's rural hospitals, they act not only in providing safer anesthetic care in the operating room, but also in labor and delivery and in the triage and resuscitation of trauma in the emergency room until patients can be airlifted out to a higher level of care. An anesthesiologist is frequently the most experienced physician in these facilities to provide resuscitation and critical care. Congress and the Administration should seek to transform rural hospitals to be able to immediately stabilize patients for transport as well as to provide labor & delivery, especially when there isn't time to transport. Physician anesthesiologists can be part of the solution to improving the poor outcomes we see in rural hospitals.

ASA's Perioperative Surgical Home (PSH) is a coordinated care model that is already making a difference in the lives of patients residing in some rural and underserved communities. Created by leaders within the ASA, the PSH is a patient-centered, physician-led, coordinated model of care for invasive procedures, designed to achieve the quadruple aim of improving population health, reducing costs, gratifying providers and satisfying patients. One rural Southeast hospital has implemented telehealth methods as part of the PSH which has led to faster recovery times, a decrease in surgical site infections, and a decrease in patients' burden from traveling for multiple in-person visits, as well as a decrease in length of stay and readmissions; and adoption of opioid-sparing protocols as are seen in all institutions, which speaks to the universal applicability of the PSH model.

Anesthesiologists, as part of the PSH champion triad (typically an anesthesiologist, surgeon and hospital administrator), often lead PSH efforts that have improved health outcomes in diverse health care settings and any surgical service line, including rural areas and underserved communities. Central to the PSH is shared decision making and continuity of care for patients, from the decision for an invasive procedure through recovery and beyond. When implemented, the PSH model builds the infrastructure to screen and address social determinants of health (SDOH), chronic conditions, and use telehealth when clinically appropriate. Since the PSH model focuses on a patient's full surgical journey, weight loss, smoking cessation, and addressing comorbidities (e.g. diabetes and cardiovascular disease) occurs upstream to achieve better health outcomes.

Integral to the PSH model are patient safety and quality, which are often among the first outcome measures captured by systems that pilot PSH programs. Institutions that use the PSH model achieve these outcomes by being patient-centered and team-based. PSH integrates and de-silos the surgical journey so that the patient does not experience unnecessary testing, receives comprehensive patient education and transitional care planning. The care team sees the patient earlier than in traditional surgical care and is therefore able to reduce complications through risk stratification and preventive measures.

These efforts are even more important in rural settings due to the transportation burden for rural populations and the need for more efficiency in pre-surgery testing and screening, as well as careful transitional care management. A pre-surgery screening may be one of the few health care access points in underserved communities. If this is the case, a PSH model connects a primary care physician with the surgical care team, sharing testing results and working together on preventive interventions.

The American Society of Anesthesiologists thanks the House Ways and Means Committee for this opportunity to present proposals that could make measurable, meaningful differences in the lives of patients in rural and underserved communities. We look forward to the on-going work of the Task Force and would happy to provide additional information. Please contact Nora Matus, ASA Director of Congressional and Political Affairs at: (202)289-2222 or n.matus@asahq.org if we can be of any assistance to the Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Mary Dale Peterson, M.D. FASA".

Mary Dale Peterson, M.D. FASA
President

cc: Task Force Co-Chairs: Representatives Danny Davis; Terri Sewell; Brad Wenstrup; Jodey Arrington.