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AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Protect Access to Rural Anesthesia Services

ISSUE BRIEF

Medical deserts are appearing across rural America, leaving many of our nation's most vulnerable populations without timely access to care.

Background

According to the National Rural Health Association, 121 rural hospitals have closed since 2010, with more than 163 and counting closed since 2005. Right now, 673 additional facilities are vulnerable and could close, representing more than one-third of rural hospitals in the U.S.[1]

In fact, the rate of closure has steadily increased since sequester and bad debt cuts began to hit rural hospitals, resulting in a rate five times higher in 2016 compared with 2010. Continued cuts in hospital payments have taken their toll, forcing far too many rural hospital closures. Medical deserts are appearing across rural America, leaving many of our nation's most vulnerable populations without timely access to care.

Rural Medicare beneficiaries already face a number of challenges when trying to access health care services close to home. Seventy-seven percent of rural counties in the United States are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. Additionally, rural populations as a whole are more likely to be underinsured or uninsured, be poorer than their urban counterparts, and experience more chronic disease.

On average, rural trauma victims must travel twice as far as urban residents to the closest hospital. In an emergency, every second counts! As a result of these disparities, 60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas. But the situation is poised to get even worse. **If the 673 vulnerable hospitals closed, rural patients would need to seek alternatives for 11.7 million hospitals visits, 99,000 health care workers would need to find new jobs, and $277 billion in GPD would be lost.**

[1] https://www.ruralhealthweb.org/advocate/save-rural-hospitals

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RURAL HEALTH DURING COVID-19

Many U.S. hospitals and health systems have suspended elective procedures to save capacity, supplies and staff to treat COVID-19 patients. As a result of suspending these procedures, several systems have lost or expect to lose a large chunk of their annual revenue, forcing them to make cost reduction a top priority.

239

Number of hospitals and hospital systems that have furloughed tens of thousands of employees.

SOURCE: Becker's Hospital Review

86%

Percentage of CRNA 1099 independent contractors who have either been terminated, furloughed, or face significantly reduced hours.

SOURCE: AANA Membership Survey

60%

Percentage of CRNAs who are W2 employees who faced furloughs or reduced hours.

SOURCE: AANA Membership Survey

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CRNA Role in Rural Health

CRNAs play an essential role in ensuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

The importance of CRNA services in rural areas was highlighted in a recent study that examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[2]

[2] *Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurse Econ. 2015;33(5):263-270. https://www.semanticscholar.org/paper/Geographical-Imbalance-of-Anesthesia-Providers-and-Liao-Quraishi/77112f1f7ca09a86142b4f5e7c065ae9a073dec2*

CRNA Role in COVID-19

CRNAs are uniquely trained and positioned to treat COVID-19 patients in this pandemic. All CRNAs have at least one year of experience as an RN in a critical care setting, with the average CRNA having 3 years of this experience before becoming a CRNA.

CRNA expertise in airway management, hemodynamic monitoring, management of patients on ventilators, placement of invasive lines, and overall management of critically ill patients uniquely positions them to provide life-saving care to those suffering from COVID-19. A recent CMS report on patient services noted that CRNAs are among the top 20 specialties that served the most beneficiaries between March 2020 and June 2020, during the beginning of the pandemic.

Anesthesiologists' participation in the rural pass-through program would increase cost to Medicare at a time when Medicare dollars are tight.

Current State of the Issue

In 2009, acting CMS administrators twice overruled the agency's Provider Reimbursement Review Board (PRRB) and wrongly denied rural hospitals pass-through payment for CRNAs' standby and on-call services even though such payments are clearly permissible and necessary to rural hospitals' emergency care and trauma stabilization capabilities. **These CMS rulings have denied rural hospitals' claims for tens of thousands of dollars each in annual Medicare funding that they had come to rely upon to serve their communities.** The AANA has worked to restore CRNA on-call payments in the rural pass-through program. In past Congresses, legislation was introduced to clarify reasonable costs for critical access hospital payments under the Medicare program. The legislation, titled the Critical Access and Rural Equity (CARE) Act, would resume passthrough payments for CRNA "on call" services.

Services of anesthesiologists remain ineligible for pass-through funding. Therefore, they or the hospital must bill Medicare Part B for anesthesiologists' anesthesia services. During the 116th Congress, Representatives Emanuel Cleaver (D-MO) and Jason Smith (R-MO) introduced HR 2666, the ASA supported Medicare Access to Rural Anesthesiology Act of 2019, making anesthesiologists eligible to participate in the pass-through program. This bill did not move in Congress and has not yet been reintroduced. The AANA expressed opposition to this legislation because if it is signed into law, it will increase costs to the Medicare Part A program and promote remote "supervision" instead of rural anesthesia professionals on site. Anesthesiologists' participation in the rural pass-through program would increase cost to Medicare at a time when Medicare dollars are tight.

Representatives Sewell (D-AL) and Tom Reed (R-NY) introduced the Rural Hospital Support Act (H.R. 1887). The legislation is intended to extend and modernize critical federal programs that rural hospitals rely on to properly serve their communities. This includes renewing the Medicare-dependent Hospital (MDH) and Low Volume Adjustment programs, as well as updating Medicare reimbursement formulas for Sole Community Hospitals (SCHs) and MDHs.

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The AANA is partnering with the National Rural Health Association to form a coalition of healthcare groups and interested parties called the Rural Health Action Alliance.

Anticipated Future State

It will be important to continue to seek support from Congress to restore on-call payments to CRNAs. ASA has continued to support rural pass-through legislation for anesthesiologists. The AANA will monitor the status of critical access hospital and rural health legislation introduced in the current Congress.

Equally important, the AANA is partnering with the National Rural Health Association to form a coalition of healthcare groups and interested parties called the Rural Health Action Alliance.

OUR MISSION

The Rural Health Action Alliance is committed to delivering high-quality, cost-effective healthcare to patients in rural areas. Through advocacy and education, the Rural Health Action Alliance seeks to improve federal policy related to rural healthcare.

OUR VISION

Consisting of groups representing patients, providers, and other interested parties, the Rural Health Action Alliance offers an opportunity to coalesce around issues and ultimately advocate for federal laws and policies that will benefit rural areas.

OUR VALUES

- **R**ealizing that patients in rural areas deserve more equitable healthcare policies
- **U**niting for or against policy and laws
- **R**especting diverse coalition membership priorities
- **A**cting as a voice for rural America to educate the federal government
- **L**obbying the federal government on priorities

Most recently, the RHAA sent a letter to Congress, outlining the coalition's priorities in any future legislation to address the COVID-19 pandemic.

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IMPORTANT MILESTONES

OCTOBER 2019
The previous administration issued Executive Order 13890, *Protecting and Improving Medicare for Our Nation's Seniors.* Section 5 of the Executive Order directs the U.S. Department of Health & Human Services (HHS) to eliminate burdensome regulations and unnecessary supervision requirements in the Medicare Conditions for Participation guidelines, within one year of the Order.

MARCH 30, 2020
CMS temporarily removed Medicare physician supervision requirements for CRNAs and other unnecessary barriers for qualified advanced providers during the COVID-19 pandemic.

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Supervision Removal of CRNAs as a Solution to Rural Health

As the nation looks to gradually reopen the economy, resuming elective surgeries will put a dramatic strain on hospitals. Removing unnecessary supervision requirements would increase the capacity of the healthcare workforce when that capacity could become severely strained, particularly in rural areas. We need to ensure the U.S. has every available provider practicing at the top of their abilities to deal with the aftermath of COVID-19.

Moving forward immediately with the removal of Medicare Part A Conditions of Participation supervision requirements is in line with the President's Executive Order, the Centers for Medicare and Medicaid Services' Rural Health Strategy report, "Reforming America's Healthcare System through Choice and Competition,"[4] and with recommendations from independent arbiters like the New England Journal of Medicine.[5] Simply put, now is the time to act.

[4] *https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf*

[5] *Frogner, Fraher, Spetz, Pittman, Moore, Beck, Armstrong and Buerhaus. (2020) Modernizing scope-of-Practice regulations – Time to Prioritize Patients. New England Journal of Medicine.382;7.p591-593*

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