

House Health and Human Services Committee
Testimony Re: HB 2295
Presented by Dr. Juan Quintana
February 18, 2019

Madame Chairman and honorable members of the committee,

Re: Opponent of HB 2295 licensure of AAs in Kansas.

The healthcare landscape in the United States is changing, and professionals whose services result in cost-effective, efficient, high-quality, safe outcomes will be needed more than ever. Today, a large segment of our population is moving into retirement. It is estimated that currently, Medicare enrollees approximate 42 million and that by 2030, they will increase to 80 million. These folks will need more care and more access to quality safe cost-effective services. Nurse Anesthetists and Anesthesiologists play a critical role in meeting that challenge by providing PROVEN safe, quality anesthesia care efficiently at a cost that ensures access to anesthesia for millions of Americans.

My name is Dr. Juan F. Quintana, DNP, MHS, CRNA, and I come before you today as a former President for the American Association of Nurse Anesthetists, speaking against the credentialing of AAs to practice in Kansas. I am humbled to appear before you to bring a national perspective and a little of our experience in Texas. I come to you with 21 years of practice as a CRNA, a veteran and a business owner. In Gallop polls, nursing has been voted the most honest and ethical healthcare profession 16 years running.

I'd like to start by framing this from an historical perspective on the education of anesthesia providers. CRNAs are first RNs with a bachelor's degree and an average 3 years of ICU experience BEFORE matriculating into a nurse anesthesia program which results in approximately 6 years of nursing experience, 3 years anesthesia specific. Anesthesiologists must have completed their 4 year MD degree BEFORE entering their residency programs which results in a 3-4 year anesthesia specific education. Prior to ever putting hands on a patient from an anesthesia perspective, both have years of hands on experience working with patients. AAs are not PAs. The education of AAs requires no prior hands on experience with patients. And yet, within 24 months, they can begin administering medications that make patients, including your parents and children, unconscious and stop your breathing. In fact, they can take their accreditation test after 18 months of education. (Exhibit 1)

Perhaps, I would feel better, if I had well-documented, reasonable peer reviewed evidence to support AA utilization, but I don't. Both CRNAs and Anesthesiologists have a peer reviewed body of evidence proving their quality and safety in the provision of anesthesia services. Studies by nationally respected researchers time and again have shown that the administration of anesthesia services is equally safe when administered by CRNAs or anesthesiologists (see references).

Kansas has personal experience in the safety of CRNAs - for the last 15 years, CRNAs have been the solo providers of anesthesia services in 65 counties with excellent results. In fact, data obtained from CMS regarding the billing of anesthesia services by CRNAs in Kansas indicates that approximately 53% of all anesthesia is done by CRNAs alone (QZ modifier), and another 17% is done with anesthesiologists (QK modifier), meaning at least 70% of all anesthesia in Kansas is done with CRNAs. This point is **critical** since it's clear that CRNAs provide quality, safety and access to services in a cost-effective manner that no other provider brings to the table and that interference with the ability of Kansas to obtain and maintain CRNA services can be critical, in fact **harmful to the public** in the ability to provide surgical services. This trend has been consistent for over a decade. (Exhibit s 2-3)

The military uses CRNAs in FST on the front lines of conflict, they use Anesthesiologists in field hospitals, but they don't use AAs. The ability of each anesthesia provider to administer quality, safe anesthesia without need of additional oversight expands access to anesthesia services.

Access to services **directly impacts** the Kansas citizens. Any reduction in available proven resources harms the public. AAs don't increase access to services due to their reliance on anesthesiologist's supervision. The education of AAs therefore reduces the valuable clinical educational slots needed to support the PROVEN providers of anesthesia services. A recent study¹ published in the September/October 2015 Nursing Economic\$ found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed. Access to services is imperative. Valuable, yet limited, Kansas resources should be optimized to achieve the goal of providing outstanding care from proven providers.

Speaking of resources, I have mentioned several times about the need for quality, safe, accessible, cost-effective anesthesia services. This brings me to another problem with utilization of AAs in the workplace. Anesthesiologists have indicated that AAs must work under direct medical direction. Medical direction is an anesthesia practice model term which means that one anesthesiologist works directly with 2-4 AAs.

Of course, given the educational history of AAs (Exhibit 1), their lack of experience prior to entering anesthesia programs, and the glaring lack of evidence to prove their quality and safety, one would hope anesthesiologists could guarantee us all that they would be immediately available to assist these folks as they move our parents and children into unconsciousness and stop their breathing during anesthesia, but they don't. Epstein and Dexter, two anesthesiologists, proved in a simple study that we can safely expect the anesthesiologist to be available to the AA, 65% of the time if they are 1:2 ratio and 1% of the time if they are 1:3 ratio. A 65 is a failing grade where I come from.

Hospitals are adversely affected by the use of AAs in the workplace through cost and potential fraud. The medical direction model of anesthesia services is one of the

costliest and by far the most inefficient (Exhibit 2). AAs are tied to having an anesthesiologist available and rightly so. However, this means each anesthetic has to be administered by two providers. This adds additional costs to the facility. Usually, CRNAs and Anesthesiologists administer anesthesia without need of two providers. Hospitals using medical direction practice model are trapped into spending millions of dollars to sustain this practice model. If a facility had, for example, 12 anesthetizing locations, the base staffing model 2 AAs /1 MDA would be 12 AAs and 6 MDAs. The base cost of using this model would be a minimum of \$4.52M and, given the fact that, according to Epstein, the medical direction model would fail 65% of the time, the exposure to fraudulent billing would be frightening (Exhibit 3). This flies in the face of the impact on healthcare costs: In addition, workforce studies have shown that academic facilities using medical direction models, on average, subsidized anesthesiologists over \$130,000 per anesthesiologist in order to sustain this model of practice. In other words, 10 anesthesiologists with AAs results in \$1.3M dollars coming out of the facilities pocket to support the anesthesia department. Instead of hospital wide efforts to improve quality and safety of patients, the money goes to the anesthesia department. Imagine, given this simple example, putting \$1.3M dollars **back** in the pockets of hospitals. All this at a time when revenue is declining, and the number of Medicare recipients is doubling in healthcare.

Relating to healthcare costs, I provide the following information. 3 Studies, 2 from the Lewin Group and one from the Research Triangle Institute, starting in 2010 and the last in 2016 found; A CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery (Lewin 2010), noted that there are no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians (RTI 2010), and noted when CRNA practice to their full authority, there was no measurable impact on anesthesia-related complications (2016). The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less. The results of the Lewin study are particularly compelling for people living in rural and other areas of the United States where anesthesiologists often choose not to practice for economic reasons. Kansas has had it right all along!

AAs cannot be flexible and meet the growing needs of the facility. Anesthesiologists do not meet the TEFRA rules required under Medicare rules to appropriately run Medical Direction models of practice, resulting in fraud. Today, anesthesia practice models are changing with an increased focus on quality, safety, inefficiency, access and cost-effectiveness. CRNAs and anesthesiologists working together can effectively bring all this and more to facilities (Exhibit 4). Perhaps if AAs could be used in a more flexible manner or brought a large measure of cost reduction to the system, we could work to mitigate their lack of education, lack of evidence of quality and safety and potential fraud, but they don't.

Finally, the AAs serves only to amplify the billing possibilities of anesthesiologists. The anesthesiologists can bill up to 200% of what they can bill if they personally performed the anesthesia.

In summation:

Perhaps, I would feel better if I had well documented reasonable peer reviewed evidence to support AA utilization, **but I don't.**

The military uses CRNAS in FST on the front lines of conflict, they use Anesthesiologists in field hospitals, **but they don't use AAs.**

Valuable, yet limited, Kansas resources should be optimized to achieve the goal of providing outstanding care from proven providers.

One would hope that anesthesiologists could guarantee to be immediately available in the operating arena when our parents and children are put into unconscious states **but they won't.**

Thank you,

Dr. Juan F. Quintana DNP, MHS, CRNA

Additional research sources:

A 2008 study titled, "Anesthesia Provider Model, Hospital Resources, and Maternal Outcomes." That study, led by Drs. Jack Needleman, PhD, MS and Ann Minnick, PhD, RN, FAAN, concluded that obstetrical anesthesia is equally safe in hospitals that use only CRNAs or a combination of CRNAs and anesthesiologists, compared with hospitals that use only anesthesiologists.

A 2007 study titled, "Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery." That study, led by Daniel Simonson, CRNA, MHPA, concluded there is no difference in complication rates or mortality rates between hospitals that use only CRNAs compared with hospitals that use only anesthesiologists.

A 2003 study titled, "Surgical Mortality and Type of Anesthesia Provider." The study, led by Dr. Michael Pine, a board-certified cardiologist, concluded that patients are just as safe receiving their anesthesia care from CRNAs or anesthesiologists working individually as from CRNAs and anesthesiologists working together.

Nurses Remain Nation's Most Trusted Professionals - *Medscape* - Dec 06, 2012.

Liao CJ, Quraishi JA, Jordan LM (2015). Geographical imbalance of anesthesia providers and its impact on the uninsured and vulnerable populations. *Nursing Economic\$,* 33(5):263-270.

Hogan, P., Seifert, R., Moore, C., Simonson, B. "Cost Effectiveness Analysis of Anesthesia Providers." *Journal of Nursing Economic\$.* May/June 2010. 28, No. 3. 159-169.

Institute of Medicine. (2010). The future of nursing: Leading change, advancing health. Available at <http://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Press-Release.aspx> .]

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Pine, M, Holt, KD, Lou, YB. "Surgical Mortality and Type of Anesthesia Provider." *AANA Journal.* 2003; 71:109-116.

Workforce and Finances of the United States Anesthesiology Training Programs: 2009–2010 Khetarpal, Sachin MD, MBA; Tremper, Kevin K. PhD, MD; Shanks, Amy MS; Morris, Michelle MS *Anesthesia & Analgesia: June 2011 - Volume 112 - Issue 6 - p 1480–1486* doi: 10.1213/ANE.0b013e3182135a3a Economics, Education, and Policy: Brief Report

Medicare Part B Carrier Summary Data Files

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-Carrier-Summary-Data-File/Overview.html>



CRNA



AA

CRNA

VS.

AA

Certified Registered Nurse Anesthetists

AUTONOMOUS, safe, cost-effective—
ensure access to care

CRNAs are educated to be an **AUTONOMOUS** anesthesia provider and are qualified to make **INDEPENDENT** judgements regarding all aspects of anesthesia care. CRNAs and anesthesiologists can work **INDEPENDENT** of one another or together.

The most cost-effective anesthesia delivery model is a CRNA working **AUTONOMOUSLY**. A CRNA working **AUTONOMOUSLY** can provide the care that requires two providers when the anesthesiologist-AA model is used.

CRNAs work in urban and rural areas, and across all types of practice settings. CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care in rural areas.

CRNAs are **AUTONOMOUS** within a patient care team regardless of the composition of that team. CRNAs provide high quality anesthesia care with or without physician oversight.

CRNAs provide quality care with or without physician oversight. When working in the anesthesia care team, if there is no supervision, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction).

CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.

Applicants for nurse anesthesia programs have acquired extensive clinical experience in a variety of areas such as coronary, respiratory, postanesthesia, and surgical intensive care units before they begin their nurse anesthesia programs.

CRNAs receive 7-8 1/2 years of formal education and preparation, from commencement of the professional education in nursing to graduation from nurse anesthesia school. During the course of their education, CRNAs will typically have acquired, on average, 8,636 hours of clinical patient care experience.

Anesthesiologist ASSISTANTS

DEPENDENT, costly—do not
improve access to care

AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist.

AAs are **DEPENDENT** practitioners that must work with a supervising anesthesiologist; therefore, it takes two providers to provide anesthesia care to one patient, which is not a cost-effective model of care.

AAs are **DEPENDENT** practitioners who cannot expand access to care. AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.

AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision².

AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.

AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.

AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.

Clinical hours for AA programs include experiences such as learning to do physicals, taking patient histories, training and certification processes for life support training, and other learning experiences that a licensed professional RN has already mastered prior to nurse anesthesia program entry. During their AA program, AAs students average 2,600 hours of clinical anesthesia education.

¹ As used in this document, "supervision" also refers to "medical direction" under TEHRA (The Equity and Fiscal Responsibility Act of 1982)

² "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as stated in under TEHRA

state ▼

Sum of allowed

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%



2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

year ▼

Modifier ▼

- OZ
- QK
- OTHER
- AD
- AA

state	KANSAS
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Sum of allowed	Modifier				
year	AA	AD	OTHER	QK	QZ
2005	16.3%	0.0%	14.5%	11.7%	57.5%
2006	12.9%	0.0%	19.3%	16.5%	51.3%
2007	11.2%	0.0%	19.5%	17.5%	51.7%
2008	11.4%	0.0%	20.6%	17.4%	50.6%
2009	10.7%	0.2%	21.0%	17.2%	50.9%
2010	10.6%	0.3%	21.1%	17.2%	50.7%
2011	10.1%	0.3%	22.3%	17.9%	49.4%
2012	9.8%	0.3%	23.1%	18.3%	48.6%
2013	8.9%	0.0%	25.3%	19.7%	46.0%
2014	8.0%	0.0%	25.9%	20.6%	45.5%
2015	7.8%	0.2%	22.9%	17.8%	51.3%
2016	6.9%	0.6%	22.8%	16.9%	52.8%

AAs

Anesthesiologist
ASSISTANTS

INFLEXIBLE STAFFING STRUCTURE POTENTIAL **REDUCED REVENUE**

AAs are **only** able to provide anesthesia care **under the direct supervision** of a physician anesthesiologist.

Physician anesthesiologists can only bill for AAs when medical direction criteria are met.

**AAs CANNOT work
Autonomously**



**AAs CANNOT
Collaborate with Surgeons
or Proceduralists**



**Medical Direction (QK)
TEFRA¹ Compliance
Capability**

(2:1 Ratio)



AA + ANES²

12 + 6

Staffing Cost³

4.52M

**Failed Medical Direction
(QK) defer to Supervision
(AD) Billing**

(3:1 Ratio)



AA + ANES²

12 + 4

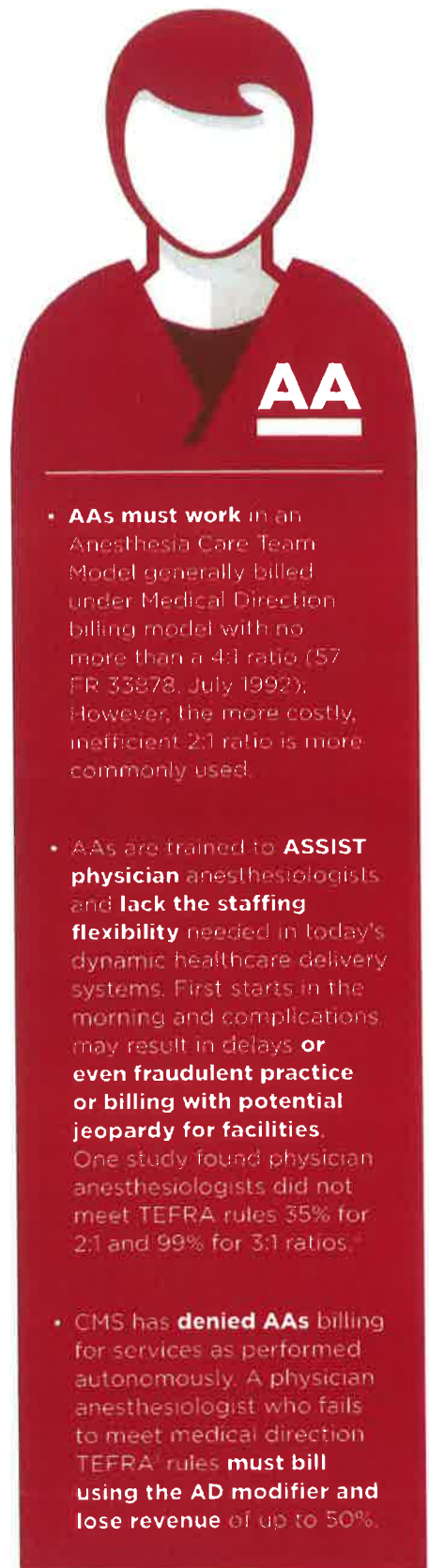
Staffing Cost³

3.68M



**Significant Risk For
Medicare Fraud**

Reduced Revenue



- **AAs must work** in an Anesthesia Care Team Model generally billed under Medical Direction billing model with no more than a 4:1 ratio (57 FR 33878, July 1992); However, the more costly, inefficient 2:1 ratio is more commonly used.
- AAs are trained to **ASSIST** physician anesthesiologists and **lack the staffing flexibility** needed in today's dynamic healthcare delivery systems. First starts in the morning and complications may result in delays or **even fraudulent practice or billing with potential jeopardy for facilities**. One study found physician anesthesiologists did not meet TEFRA rules 35% for 2:1 and 99% for 3:1 ratios.⁴
- CMS has **denied AAs** billing for services as performed autonomously. A physician anesthesiologist who fails to meet medical direction TEFRA¹ rules **must bill** using the AD modifier and lose revenue of up to 50%.

1 Tax Equity and Fiscal Responsibility Act of 1982

2 Physician anesthesiologist

3 Staffing costs are based on salary only and provider billing cost ratios are comparable when using median CNA salary (\$106,574) according to 2018 AANA Compensation & Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th percentile salary (\$470,284) according to IHR Reported data as of March 29, 2018 from Salary.com

4 Epstein H, Dexter T. (2017) Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics. Anesthesiology. 116(3) 683-691


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AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

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CRNAs

Certified Registered Nurse Anesthetists

Are the Most **VERSATILE**
and **COST-EFFECTIVE**
ANESTHESIA PROVIDERS



CRNA

- CRNAs are qualified to work in any practice setting/model
- CRNAs are not required to practice under a physician anesthesiologist; by law, CRNAs can work independently of OR together with physician anesthesiologists
- CRNAs have a proven safety record
- CRNAs in Anesthesia Care Team Model ensure **NO LOSS IN REVENUE, NO RISK OF FRAUD**, no delays in delivery of care even when there is a supervision lapse (up to 70%² of the time) as long as QZ billing is utilized
- In such cases, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction). The QZ modifier is exclusive to CRNAs

Cost Effectiveness of Anesthesia Models

Autonomous/CRNAs
Collaborating with
Surgeons



CRNA

12

Staffing Cost²

2.00M

CRNAs
Collaborating with
Anesthesiologists



CRNA

ANES¹

12

1

Staffing Cost²

2.40M

Physician
Anesthesiologist Only



ANES¹

12

Staffing Cost²

5.04M

Anesthesia Care
Team
(3:1 Ratio)



CRNA

ANES

12

4

Staffing Cost²

3.68M

¹ Physician anesthesiologist

² Staffing costs are based on salary only. The median CRNA salary (\$116,541) was taken from the 2018 AANA Compensation and Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th percentile salary (\$270,285) according to HR Reported as of March 20, 2018 from Salary.com.

³ Estimated. Deterf, J. (2012). Influence of supervision ratios by anesthesiologists on first case volume and critical persons of anesthesia. Anesthesiology 112(1):183-191.

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