Testimony Re: SB 223
Presented by Kyle Nevills
Senate Public Health and Welfare Committee
March 18, 2019

Chairman Suellentrop, and members of the Health Committee,

Thank You for allowing me the opportunity to speak to you today regarding this very important issue before you. My name is Kyle Nevills. I am a Certified Registered Nurse Anesthetist (CRNA) and I am the President of the Kansas Association of Nurse Anesthetists. I represent over 700 CRNAs and student registered Nurse Anesthetists (SRNAs) in the great state of Kansas. I was born and raised and educated in Kansas. I attended the University of Kansas to obtain my Masters in Nurse Anesthesia in 1992. I have practiced thru out Kansas during my career working in Level 1 Trauma centers as well as rural hospitals in Central and western Kansas. While working in Wichita, Kansas during my early career, I chose to work in an Anesthesia Care Team model of Practice. By that I mean I worked within a team of both CRNAs and Anesthesiologists. I worked in this model for about 2.5 years. For the next 24 years I have worked without any anesthesiologist involvement. I have found it personally more satisfying and rewarding to practice independently and make my own decisions regarding the care of my patients. I tell you this because I also feel it is the way that many of the CRNAs in the state feel. Part of the beauty of Kansas is that one can choose to live in very urban areas of the state or very rural areas of the state. Both have their attractions for certain types of people. Currently in Kansas there are two types of providers licensed to perform surgical anesthesia. One is the MD or DO provider and the other is the CRNA. Both types of these providers may practice in any part of the state, with or without the involvement of the other type of provider. There exists what I like to call a geographic maldistribution of the Anesthesiologists in the state.

If you refer to the Map we have provided for you, the blue counties represent counties that have CRNAs to provide their anesthesia services, while the red blocks represent counties that also have Anesthesiologists. Please note there are no counties that are all red. As you can see the red areas are more highly concentrated in the urban areas (Kansas City, Wichita, Topeka, Salina) Why does this make a difference?? The 435 anesthesiologists of the state seem to prefer the urban areas where they live and often work in a care team model along with CRNAs. Many CRNAs also enjoy living in these urban areas and also choose to work in this care team mode.

The introduction of AAs into the state will impact the training of our student nurse anesthetists. This is important because when our students are unable to get their training requirements, our two nurse anesthesia programs will be forced to find other clinical sites, forcing our students to travel further or to other states to acquire their training requirements. When this happens, the students will often choose to leave the state upon graduation. Kansas **CAN NOT** afford to lose these students as they serve the largest portions of the state. Why would Kansas want to harm the provider that provides the greatest amount of coverage to the state and has an excellent safety record and is a known quality provider? Our opponents to this bill will tell you that this is

not their intent. They do not wish to displace CRNAs or our students and that in their experience everyone is one happy family. We have brought speakers in today from Missouri where AAs have been introduced and have displaced CRNAs and student CRNAs.

I believe it is important for the committee to understand why the Kansas Society of Anesthesiologists wants this bill to pass so desperately. CRNAs and Anesthesiologists can both perform anesthesia for surgical patients independent of each other. In these circumstances the reimbursement for the services is identical in most cases. This is because CRNAs are recognized to be quality providers of anesthesia. We can perform general anesthesia, regional anesthesia (spinals, epidurals, nerve blocks to control post-operative pain) as well as sedation services and pain management procedures. We do not require a collaborative agreement as other Advanced Practice Registered Nurses do. We work in collaboration with the surgeons or physicians or dentists that we are working with. There is absolutely no requirement that an Anesthesiologist supervise a CRNA in any way shape or form. It is up to the hospital to determine which model of care is practiced within its operating rooms.

Anesthesiologists won the right decades ago to supervise CRNAs by lobbying hospital administrators and government officials. By obtaining this right they can supervise up to 4 CRNAs or AAs at a time. By doing this they may collect up to 50% of the total fee FOR EACH of the CRNAs or AAs they supervise. As an example, if either a CRNA or an anesthesiologist personally performed an anesthetic for a gallbladder surgery and the fee was $700.00 than they would each receive that amount. If the Anesthesiologist supervises 4 CRNAs or AAs doing the exact same gallbladder surgery than the CRNA would collect 350$ for the same case, that they would have received 700$ before, but the anesthesiologist would collect 350$ for each of the 4 CRNAs-1400$ where they would have received $700 if they would have performed the case themselves. This is a very important factor to remember.

Because AAs are limited in that they can only perform directly under an Anesthesiologist and not independently as CRNAs can do, the AAs are not a threat or competition to the Anesthesiologists. Because of this FACT some anesthesiologists would rather employ AAs because they will always have a job "Supervising Anesthesiologist Assistants". The Anesthesia care team model is the most expensive model for the delivery of Anesthesia. Many hospitals are now recognizing this fact and the fact that **multiple studies have shown no difference in patient outcomes** regardless of whether the anesthesia is provided by a CRNA practicing alone, a physician practicing alone, or both CRNAs and Anesthesiologists practicing together. Many large hospitals have recognized this and have started to switch their practice model to allow CRNAs to practice independently. This is a direct threat to Anesthesiologists job security. By employing AAs, they decrease their competition (CRNAs) and assure themselves of jobs because AAs cannot practice independently and will always require the presence of an Anesthesiologist.

The other issue that needs to be brought up is that you are always paying for more than 1 one anesthesia provider when you practice in a care team model. CRNAs have the ability to practice

independently even if the anesthesiologist is not available or even in the building. This is not true of AAs. The opposition likes to say that we are interchangeable—but we are not.

I would also like to point out that the opposition likes to call us MID-Level providers or physician extenders. We strongly object to this as it denotes that they are practicing at a higher level of care than CRNAs. There is nothing MID- LEVEL about the care that I or any of my colleagues provide to our patients. There is ONLY ONE STANDARD for Anesthesia Safety. There are not two levels one for physicians and one for CRNAs. The American Society of Anesthesiologists has conducted research and distributed to their membership on what to call CRNAs to diminish our excellent record of patient safety to the public. They like to use the term mid-levels and like to call CRNAs just nurses. (American Society of Anesthesiologists. Messaging, Research, Findings and Recommendations. July 18, 2013).

Another area that is of concern is the lack of prior healthcare experience that AAs have prior to attending AA school. There is no requirement that they have to have had prior experience caring for patients. CRNAs on the other hand must be a REGISTERED NURSE with a bachelor's degree. Not only must they have a degree in Nursing, they must have completed courses in chemistry, microbiology, human anatomy and physiology, and statistics. They must already be certified in Advanced Cardiac Life Saving and Pediatric Advanced Life Saving. They must also have at least 1-year experience working in an Acute/Intensive care setting. Most applicants to CRNA programs have 3-5 years' experience before they apply to a nurse anesthesia program. While in this intensive care setting, they must be experienced in caring for patients on ventilators, be able to interpret EKGs, be experienced with dealing with multiple medications and technology. They must be able to think independently to care for their patients. The Critical Care Registered Nurse Certification is also highly recommended prior to application. These are all things that must be accomplished or mastered **prior** to the student ever being accepted into a CRNA program. The Nurse anesthesia program is a very challenging program varying between 2-3 years. All CRNA programs will shortly be a 3-year Doctorate level education. Students are taught by Anesthesiologists and CRNAs both in urban hospitals and rural hospitals where they gain invaluable experience working without anesthesiologists and learning to care and make decisions independently. At the end of their training they are uniquely qualified to choose whether they would like to practice in an urban area or a rural area.
The AA student may come to the program without ever having physically laid hands on a patient. They must try to learn everything about anesthesia and try to pick up within their program many of the things that CRNA students have known and performed for years, such as physical assessment of a patient. I am not trying to diminish AA students or AAs as they are obviously intelligent and caring people. They are not trained to think or act like CRNAs are.

Another issue that has been increasingly important is the area of supervision and fraud in Anesthesia billing. In order for the Anesthesiologists to collect the greatest fee they must adhere to the TEFRA guidelines. These guidelines were introduced to eliminate fraudulent billing practices in Anesthesia practices. In order to qualify the anesthesiologist must complete seven tasks. Some of these requirements are that they must perform a pre-anesthetic

evaluation, prescribe the anesthesia plan, personally participate in the most demanding parts of the anesthetic. These are Medicare or CMS rules that must be followed, or federal charges of Medicare abuse can and have been filed. One Anesthesiologist can supervise 4 CRNAs or 4 AAs. If for some reason the Anesthesiologist becomes involved in an emergency in another room or called away for an emergency C-section, who is now supervising the CRNAs or the AAs?? Because of our independent status and recognition by CMS the CRNAs can continue to perform their cases without any supervision. The billing can be changed to reflect the CRNAS were practicing without anesthesiologist supervision or direction. In the case of the AAs this is simply not possible because they function in a dependent role. This would constitute fraudulent billing. An Article published in the journal of Anesthesiology (Influence of Supervision Ratios by Anesthesiologists on first case starts and critical portions of Anesthetics. Anesthesiology) in showed that Anesthesiologists failed to meet these standards 14-87% of the time at even a 1:2 ration must less 1:3 or 1 :4 ratio. In the case of CRNAs these lapses could be corrected due to the anesthesiologist's absence by changing the billing method because CRNAs can practice in an independent model, however this IS NOT TRUE of AAs. How could the Anesthesiologists `effectively supervise the AAs when their own research has shown that they fail to do so 14-87% of the time with CRNAs in a 1-2 ratio. This would constitute fraud and would leave the hospital and surgeons open to possible liability.

In conclusion I would like to reiterate that **CRNAS WORK FOR ALL OF KANSAS**, not just the rural areas, or the urban areas, but we serve in all of Kansas. Allowing the introduction of this bill will harm the pipeline of our supply of our SRNAs/ CRNAs that work for **all of Kansas**.

Thank you.

Dr. Kyle Nevills DNP, CRNA, NSPM-C
President of the Kansas Association of Nurse Anesthetists

CRNA VS. AA

Certified Registered Nurse Anesthetists **AUTONOMOUS**, safe, cost-effective—ensure access to care	Anesthesiologist **ASSISTANTS** **DEPENDENT**, costly—do not improve 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.	AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist[1].
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.	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.
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.	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.
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.	AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision[2].
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).	AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.
CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.	AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.
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.	AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.
CRNAs receive 7-8 ½ 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.	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 TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist [illegible] to be physically present [illegible] TEFRA.

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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

Medical Direction (QK) TEFRA[1] Compliance Capability

(2:1 Ratio)

AA + ANES[2]

12 + 6

Staffing Cost[3]

4.52M

AAs CANNOT Collaborate with Surgeons or Proceduralists

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

(3:1 Ratio)

AA + ANES[2]

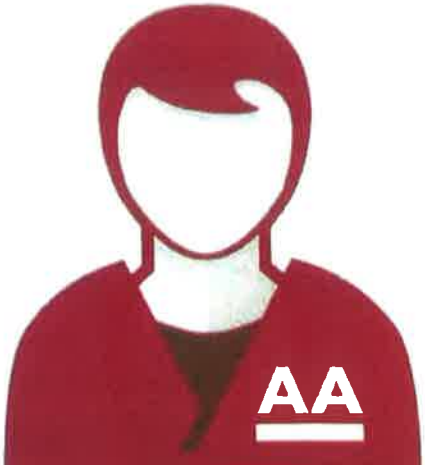
12 + 4

Staffing Cost[3]

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 4 AAs to 1 MD (57 FR 33873, 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 TEFRA 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 staffing contracts are comparable when using median CRNA salary ($168,634) according to 7:18 AANA Compensation & Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th percentile salary ($429,284) according to UR Reported data as of March 29, 2016 from Salary.com

4 Epstein R, Dexter F. (2017) Influence of supervision ratios by anesthesiologist on test case starts and critical portions of anesthetics. Anesthesiology. 116(3):683-691

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CRNAs

Certified Registered Nurse Anesthetists

Are the Most VERSATILE and COST-EFFECTIVE ANESTHESIA PROVIDERS

Cost Effectiveness of Anesthesia Models

Autonomous/CRNAs Collaborating with Surgeons

CRNA 12

Staffing Cost[2]

2.00M

CRNAs Collaborating with Anesthesiologists

CRNA 12 | ANES[1] 1

Staffing Cost[2]

2.40M

Physician Anesthesiologist Only

ANES[1] 12

Staffing Cost[2]

5.04M

Anesthesia Care Team

(3:1 Ratio)

CRNA 12 | ANES 4

Staffing Cost[2]

3.68M

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%[3] 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

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