Report of the Special Committee on Health to the 2020 Kansas Legislature

CHAIRPERSON: Representative Brenda Landwehr

VICE-CHAIRPERSON: Senator Gene Suellentrop

OTHER MEMBERS: Senators Ed Berger, Barbara Bollier, Bud Estes, and Mary Jo Taylor; Representatives Tory Marie Arnberger, John Barker, Eileen Horn, Megan Lynn, and Jarrod Ousley

STUDY TOPIC

The Committee is directed to:

- Study the licensure of anesthesiologist assistants:
  - Review 2019 HB 2295;
  - Consider the economic impact of the proposed licensure;
  - Hold a roundtable discussion of issues surrounding licensure; and
  - Receive information on the results of licensure in other states.

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Special Committee on Health

Report

Conclusions and Recommendations

The Special Committee on Health generally agreed the interested parties should attempt to resolve any issues or conflicts identified during its meeting and present an acceptable compromise during the 2020 Session.

Proposed Legislation: None

Background

The Legislative Coordinating Council (LCC) directed the Committee to study the licensure of anesthesiologist assistants (AAs). As part of this study, the Committee was directed to review 2019 HB 2295, consider the impact of the proposed licensure, hold a roundtable discussion of issues surrounding licensure, and receive information on the results of licensure in other states. The topic was requested by the Chairperson of the House Committee on Health and Human Services.

The Committee was granted one meeting day by the LCC and met October 21, 2019, at the Statehouse.

Committee Activities

The Committee held an all-day meeting October 21, 2019. During the meeting, the Committee participated in a roundtable discussion with interested parties representing anesthesiologists, AAs, certified registered nurse anesthetists (CRNAs), the Kansas Hospital Association, and the Kansas Medical Society (KMS) and asked questions of the roundtable participants concerning the licensure of AAs. The key issues and concerns presented by each of the participant groups are described as follows.

Review of 2019 HB 2295—Providing for the Licensure of AAs

Committee staff provided an overview of 2019 HB 2295, which would enact the Anesthesiologist Assistant Licensure Act.

Staff presented a background summary of HB 2295, which was introduced at the request of the Kansas Society of Anesthesiologists, and information presented in the bill's public hearing by the House Committee on Health and Human Services in February 2019. Additionally, background information was provided for 2019 SB 223 (similar legislation introduced on AA licensure) and AA licensure legislation introduced in 2017 HB 2046. During the Senate Committee on Public Health and Welfare hearing on SB 223 in March 2019, there was discussion of amendments to that bill, but no action was taken.

Roundtable Discussion on Issues Surrounding the Licensure of AAs

Educational Requirements

Anesthesiologist Assistants

A Professor and Chairperson of the Department of Graduate Health Professions in Medicine, University of Missouri—Kansas City (UMKC) provided information on the educational requirements for AAs. [*Note:* Missouri law permits the licensure of AAs. This experience in Missouri, with the anesthesia care team (ACT) model using certified anesthesiologist assistants (CAAs), was cited by proponents participating in the round table.] She noted the AA program in Missouri is a rigorous master's level program governed by an accreditation body. The program must be housed in a school of medicine that is approved by the accreditation committee for medical schools and has a graduate medical education residency program (physician resident training program) along with the AA program. The

AA program must have a medical director who is a licensed, certified, practicing anesthesiologist; a program director who is a licensed and certified AA; and sufficient physician anesthesiologists and AAs on the faculty. Requirements for applicants to the AA program include meeting prerequisite training similar to pre-health requirements for pre-medicine, pre-physician assistant, or like health professions and a minimum grade point average. The program is required to have 112 credit hours. Clinical experience is a part of the process, as is the demonstration of competency in all areas of administration and knowledge of the medications used. Additionally, the accreditation body requires a minimum of 2,000 clinical hands-on patient hours that meet specific parameters for graduation. AA programs are 24 to 28 months in duration. Upon graduation, the accreditation body also requires follow-up surveys be conducted with the anesthesiologists who hire the CAAs to determine whether the CAAs have the necessary education and training. A doctoral degree is not available for AAs.

Certified Registered Nurse Anesthetists

The Program Director of CRNA Education, University of Kansas School of Health Professions, provided an overview of CRNA educational requirements. Applicants for the CRNA Program must have a nursing background, be a registered nurse (RN), and have critical care experience. The Council on Accreditation of Nurse Anesthesia Education Programs (COA) has strict guidelines for certification. The nurse anesthetist education program is moving toward a clinical doctoral degree, with only one year remaining of admitting master's level RNs into the program. Most of the programs take place at a school of nursing, with some in schools of health professions and a couple in schools of medicine, depending on how the programs are organized. There are stringent clinical requirements at the University of Kansas requiring clinical rotations at multiple sites in a four-state area to accomplish all required clinical experience. Student registered nurse anesthetists (SRNAs) can be trained only in an operating room by a CRNA or an anesthesiologist. CRNAs can act independently of anesthesiologists but CAAs cannot. There is also an emphasis on enrolling Kansas residents into the CRNA education program. She stressed the importance of the minimum requirement of one year of critical care (intensive care unit) experience and the overall level of hands-on experience of the applicants enrolling in the CRNA program.

Information on the additional training required for the clinical doctoral degree for nurse anesthetists was provided.

Anesthesia Care Team and Role of the Anesthesiologist

An Assistant Professor of Anesthesiology at the UMKC School of Medicine and Children's Mercy Hospital provided the Committee with a description of the ACT model and the role of the anesthesiologist in overseeing the team. He stated the preference is an ACT model where the anesthesiologist is in supervisory mode and is required to be present for the beginning and end of all anesthesia cases. The anesthesiologist is medically and ethically responsible for all actions taken by the care team. Strict criteria require the anesthesiologist be available in a matter of seconds. At Children's Mercy Hospital (Missouri), the anesthesiologists try to limit supervision to two or three surgical rooms. The care teams may consist of CAAs, CRNAs, and anesthesia residents, with the supervising anesthesiologist rotating among the various surgical rooms as required to tend to the medical needs and to be ready to take on any emergency that arises. Benefits of an ACT include providing more eyes on a patient and being able to care for more patients. CAAs are not trained to act independently, which he commented is not a downside.

A hospital's physical layout may dictate whether CAAs are allowed to staff an ACT. For example, the obstetrics area at the Children's Research Institute at Children's Mercy Hospital in Missouri is considerably far from the surgical unit. When the anesthesiologist must be away from other surgical rooms staffed under an ACT model, as would be the case when an emergency surgery arises, a CRNA may be required to practice independently. It was noted, in these instances, this would allow the use of the QZ modifier. [*Note:* QZ is one of the modifiers used to report anesthesia services; this service is "CRNA without medical direction" and, under this modifier, the nurse anesthetist receives 100 percent of the allowed amount.]

Proponents of AA Licensure

Participants at the roundtable who spoke in support of AA licensure included an Assistant Professor of Anesthesiology at the UMKC School of Medicine and at the Children's Mercy Hospital; an Assistant Professor at the University of Kansas School of Medicine (KUMC); a private practice anesthesiologist and Associate Professor of Anesthesiology at KUMC-Wichita; a private practice anesthesiologist; a CAA; a Professor and Chair of the Department of Graduate Health Professions in Medicine and Assistant Dean of Graduate Studies, UMKC School of Medicine; the Director of State Affairs and General Counsel, American Academy of Anesthesiologist Assistants (AAAA); and the Director of Government Affairs, KMS.

The efforts undertaken to seek licensure of AAs through the legislative process and the health occupations credentialing process that resulted in a licensure recommendation by the Secretary of Health and Environment were described (who issued a final report to the Legislature in February 2019). The advantages of AA licensure observed in Missouri were presented. A proponent also noted efforts to reach a compromise with the CRNAs regarding the licensure of AAs had been "rebuffed."

The roundtable participants in favor of AA licensure generally stated AA licensure could eliminate hiring burdens, lower costs, and increase efficiencies. The proponents presented information and arguments outlined below to support their position.

Option for improved anesthesia care services. An increase in the number of anesthesia care providers through the licensure of AAs would be an important step to provide Kansans with the best anesthesia services. UMKC graduates 9 to 12 CAA students each year and hopes to expand to 16; some of these graduates are from Kansas and would like to practice in Kansas.

CAAs and CRNAs have different training backgrounds, but all work together as part of the ACT. The critically ill patients are typically treated at larger hospitals in large cities. These complex cases often need attention from multiple members of the ACT working together at one time, which is one reason the ACT concept works well in large hospital settings.

Addition of mid-level provider. Anesthesiologists are one of the few medical professions in Kansas without a mid-level practitioner equivalent to a physician assistant.

No outcome differences. A 2018 study by Stanford University researchers of 400,000 Medicare cases showed no outcome differences with regard to mortality, length of stay, and inpatient spending when comparing anesthesiologist led teams using CAAs versus CRNAs.

Direct CAA supervision. HB 2295 would add CAAs to the ACT, not replace CRNAs. CAAs seek to practice only under the direct supervision of an anesthesiologist as part of an ACT. The 4:1 CAA-to-anesthesiologist-supervision ratio can be difficult to manage at times, so anesthesiologists try to limit that ratio to less complicated cases and manage the timing of the anesthesia process to ensure sufficient oversight.

Rural hospital impact. Rural hospitals would not be required to implement an ACT model using CAAs. A federal rural pass-through law makes it almost impossible for an anesthesiologist to practice at a rural hospital because the anesthesiologist cannot receive full payment for services at critical access hospitals (CAHs), but CRNAs and CAAs can.

Raising salaries in Wichita to attract more CRNAs might pull those professionals out of CAHs, creating an even greater shortage in rural areas. Adding CAAs might curb the possible pull of CRNAs from rural areas.

CRNA shortage. A shortage of 15 to 20 CRNAs in Wichita has resulted in the shut down of operating rooms and a limitation in patient care. Facilities are managing using residents and *locum tenens* (temporary staff). Efficiencies have been created, but there are no reserves. *Locum tenens* are expensive, and the process of vetting and credentialing them makes it difficult to use this staff.

The numbers of CRNA graduates do not fill the staffing needs in Wichita because of the loss of

CRNAs to other locations after training, resulting in constant staff churning. One Wichita anesthesia provider group loses six to eight CRNAs per year.

The difficulty in hiring CRNAs at Children's Mercy Hospital in Missouri is likely a result of an anesthesia provider group's decision to hire CAAs, which was met with resistance from CRNAs. Additionally, the model used by some anesthesia provider groups' is very hands-on with regard to supervision, and some CRNAs may prefer a more independent role.

After Newman University graduates its last CRNA class and moves to a doctoral program in a year or two, there are concerns the CRNA shortage issue will become critical as fewer CRNAs enter the market.

Billing and supervision. The Social Security Act of 1986 allows both CRNAs and CAAs to bill independently. Changes in law made by the Tax Equity and Fiscal Responsibility Act of 1982 allow for billing when failed medical direction of CAAs occurs and is not billing fraud. Changes have also been made regarding reasonable charge versus reasonable cost. The Centers for Medicare and Medicaid Services (CMS) sets what will be paid for at a medical direction ratio of 1:4, and state statute sets a legal supervision ratio. Compliance with state statute does not necessarily mean compliance with CMS regulations. If state statute provides for a 1:4 supervision of CAAs but is silent on CRNA supervision, an anesthesiologist could supervise four CAAs and four CRNAs at the same time and be in compliance with state law, but not federal law. Kansas statute (KSA 65-1158c) allow CRNAs to work as part of a physician-directed team, but do not limit the number of CRNAs who can work on the team.

Training spots. No formal study documents a reduction in SRNA training spots with the introduction of student AAs. A possible compromise could be to find additional training centers for SRNAs. However, even if more training sites were possible, it is less likely anesthesiologists would be willing to increase training sites due to the animosity between CRNAs and anesthesiologists who support CAA licensure. Additionally, HB 2295 would allow CAAs to work in Kansas, but would not establish a CAA school in Kansas requiring training sites for its students. There could be an influx of CAAs from other states to work in Kansas.

Medical malpractice insurance. Under Kansas law, one factor in determining the providers required to participate in the Health Care Stabilization Fund (HCSF) for medical malpractice insurance coverage is whether the provider independently provides care for a patient. CAAs work under the direct, physical supervision of an anesthesiologist and would not be required to carry medical malpractice insurance.

AA Licensure in Other States

The proponents provided written testimony to address the Committee's charge regarding receipt of information on the results of AA licensure in other states. CAAs and CRNAs work side by side performing health care services as part of an ACT practice model in 16 states, including 3 of 4 states bordering Kansas. CAAs also may practice at any Veterans Affairs facilities in all 50 states.

AAs work by license, regulation, certification or a combination of those in the following states, territories, and districts: Alabama, Colorado, District of Columbia, Florida, Georgia, Guam, Indiana, Kentucky, Missouri, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Vermont, and Wisconsin. AAs are granted practice privilege through physician delegation in Michigan and Texas.

CMS recognizes both CAAs and CRNAs as non-physician anesthesia providers. Additionally, commercial insurance payers do not distinguish between the two types of providers with regard to payments for services provided under medical direction by a physician anesthetist.

Opponents of AA Licensure

Participants at the roundtable who spoke in opposition to AA licensure included a CRNA and President of the Kansas Association of Nurse Anesthetists (KANA); a CRNA and Program Director of the CRNA Education Program at the University of Kansas School of Health Professions, representing her own views; the Chief Executive Officer of Newman Regional Health in Emporia; and four additional CRNAs. Additionally, the Director of Newman University's

CRNA Program was in attendance at the meeting and was allowed to address the Committee.

The roundtable participants opposed to AA licensure presented information and arguments to support their position as outlined below.

Supervision requirement. Concern was expressed regarding the ability of an anesthesiologist in a supervisory role in an ACT to manage a 3:1 or 4:1 CAA-to-anesthesiologist ratio, especially when CAAs would require direct supervision. In the case of multiple emergency situations at one time, a patient might be put at risk if an anesthesiologist cannot be immediately available to assist four CAAs under the anesthesiologist's supervision, as required by CMS. The failure to supervise could affect hospital certification and create professional liability issues.

Referencing the seven steps required by CMS for Medicare compliance with regard to medical direction of CAAs by anesthesiologists, it was stated noncompliance with the requirements is failed medical direction and billing fraud. A study shows states that have enacted CAA legislation have 85 percent noncompliance with the CMS requirement of a 1:4 medical direction ratio. There are also issues with Internal Revenue Service (IRS) compliance in almost every state allowing CAAs because CAAs are being hired as independent contractors in violation of the IRS definition for an independent contractor. Many compliance and regulatory issues exist in states that have enacted CAA legislation.

Unfair competitive advantage. The introduction of CAAs into an anesthesiologist practice in up to a 1:4 ratio, when a CRNA who is also allowed to practice independently in the state is not allowed to supervise a CAA in a CRNA business model, creates an unfair competitive advantage for anesthesiologists.

Lack of CRNA shortage. There is a healthy manpower demand for CRNAs in Kansas, not a critical shortage as has been stated by those in favor of AA licensure. When HB 2046 was first introduced in 2017, there was a shortage of CRNAs. With the expansion of SRNA enrollment, these shortages are being addressed.

The University of Kansas Health System hired only 1 graduate from the 2019 KUMC CRNA program and 5 or 6 total CRNAs in 2019 because KUMC hired 60 CRNAs over the 2 previous years. She observed there is no shortage of CRNAs at KUMC, and there is a current hiring freeze for CRNAs. The 23 remaining 2019 graduates of the CRNA Program at KUMC were not recruited by the Wichita anesthesiology providers and left the state.

A salary survey indicates pay is lower at the Wichita anesthesiology facilities. Wichita facilities should consider raising salaries to be more competitive. It was noted there is a demand on a limited number of anesthesia providers in Wichita due to an increase in heath care facilities.

Increase in CRNA graduates. KANA has proposed a 40 percent increase in CRNA graduates over the next three years to address the shortage expressed by anesthesiologists in favor of AA licensure. KUMC is going from 24 graduates to 30-36 per year by 2022 and plans to maintain the increased enrollment numbers as long as jobs are available for graduates. Newman University's plan to expand its program from 20 to 25 per year is dependent on the availability of training sites, which could decrease due to a reduction in available training on high-risk cases if CAA licensure occurs. Texas Wesleyan University also has five, six, or seven students studying in Wichita and Topeka.

CRNAs oppose the proposed amendment allowing CAAs to practice only in the four most populous Kansas counties because the CRNA proposal to expand the number of SRNAs would cover the demands for additional anesthesia care providers in Kansas.

SRNA training sites. An AA program would reduce the number of teaching sites needed to train SRNAs. When AA programs were brought into Springfield, Missouri, Missouri State University SRNAs lost training sites at the local hospitals, requiring SRNAs to travel 30 or more miles or into Kansas for clinical training. Children's Mercy Hospital in Missouri had to send SRNAs home for the day for a lack of a clinical instructor. Anesthesiologists need CRNAs practicing independently, with most moving to the QZ model.

Difficulty was expressed in locating clinical sites for those in the SRNA program at KUMC and Newman University. A strict minimum number of required specific categories of clinical experience is needed to graduate. It is difficult to find clinical sites for certain categories (*e.g.*, cardiac, obstetrics (OB), pediatrics, and neurology) due to the limitations placed by the various hospitals in the area as to the categories of clinical experience allowed. KUMC senior SRNAs are sent to Fort Riley or Oklahoma for OB clinical experience, creating financial and emotional hardship for the students. Introducing student AAs will increase the competition for clinical sites and negatively impact available sites for SRNAs. There are also limits due to anesthesiology residents being given priority for the same training sites needed by SRNAs. CRNA schools must contract with facilities that provide training sites, and the contract process can take 6 to 12 months.

CRNA independent practice and rural hospital impact. Many rural areas of the state rely on CRNAs in independent practice to meet anesthesia care needs. It was noted 75 percent of anesthesia billing was under the QZ modifier (CRNA in independent practice). The majority of rural areas would not be able to use CAAs due to a lack of anesthesiologists to supervise them and the cost of the ACT model. It was also noted 87 hospitals in Kansas do not provide enough surgeries to financially support the ACT model.

Medical malpractice insurance. CRNAs participate in the HCSF and have medical malpractice insurance. CAAs would likely be covered under the anesthesiologist's policy; even if a CAA would be named in a lawsuit, the anesthesiologist under whose supervision the CAA practiced would ultimately be liable.

Reduced scope of practice. The difficulty in hiring CRNAs at Children's Mercy Hospital in Missouri is due in part because some CRNAs believed they were unable to work to their authorized full scope of practice; rather, their scope of practice in an ACT was reduced from that of an independent provider to that of a dependent provider.

Compromise Discussion and Position Summary

Proponents. The proponents of AA licensure stated more providers of anesthesia services could only help all areas of the state. The purpose of the legislation is to put together the best care team possible. The advantage to having another care provider working alongside an anesthesiologist in critical situations was noted. The introduced legislation allows each location to determine the best model for the location. Rural hospitals and CAHs would not be forced to staff in a particular way.

The proponents stated CAAs cannot practice in Kansas without being licensed. The legislation would create a framework to allow CAAs to be licensed. If the legislation is enacted, the CAA scope of practice and all other issues associated with the new position would be addressed. The legislation would not impact the CRNA scope of practice or require any provider to use the CAA practice model.

With regard to the shortage of CRNAs, the proponents noted the University of Kansas CRNA program could not guarantee all SRNAs would stay in the state, regardless of a focus on enrolling Kansas residents. An anesthesia provider shortage will always exist and needs to be addressed to fully staff ACTs. The licensure of AAs would allow for a large pool of qualified applicants from which to select.

Proponents indicated CRNAs control the market because no other mid-level non-physician anesthesia providers are allowed to practice in the state. With regard to anesthesiologists having a monopoly through the use of an ACT with CAA staffing, each hospital determines its own bylaws, and a proponent stated he was not aware of any hospital that would not negotiate with any group of anesthesia providers to provide the best care for its patients. Most hospitals in the metropolitan areas require anesthesiologists to be in charge of the anesthesiology programs in the hospitals. It is the proponents' belief CMS rules require anesthesiologists to be in charge of anesthesiology services at hospitals, especially with regard to sedation, so hospitals' hands are tied. It is up to hospitals to determine how they contract. The true monopolies were in rural CAHs, where anesthesiologists cannot compete because they

cannot receive funding from the federal government. As a result, anesthesiologists who want to move to rural areas would have to accept less pay than received by CRNAs.

Proponents stated they are willing to compromise on the counties where they can practice, the anesthesiologist-to-CAA ratio, and a prohibition on when a CAA school could be established in the state. Although proponents noted evidence does not suggest the introduction of CAAs has a negative influence on the number of CRNAs, a compromise to not establish a CAA school for five years was suggested to address the CRNAs' concern.

Opponents. The opponents of AA licensure expressed concern over the use of CAAs in an ACT who cannot practice independently. If multiple emergencies occur at one time and the provider available cannot practice independently, the results could be catastrophic for patients.

The opponents noted 2017 HB 2046 was proposed to eliminate critical shortages of anesthesia providers. The concern of CRNA shortages has been addressed with the increase in SRNAs being trained. With regard to training sites, the anesthesiologist-owned practices and the hospitals with whom they contract determine where training spots become available. Wichita anesthesiology practices have non-compete clauses that limit the transfer of staff to help other anesthesiology centers. A CRNA's communications with Wichita-based CRNAs do not validate a demand exists for 18-20 CRNAs in the area. The opponents indicated the counties listed in the proposed Senate Committee on Public Health and Welfare amendment to the AA licensure legislation are already completely controlled by anesthesiologist-owned groups that have contracts with the hospitals.

Further, the proposed legislation would allow anesthesiologists the use of CAAs as an additional provider to work four cases at one time. However, CRNAs who are also independent providers would not be allowed to employ CAAs and would be limited to working one case at a time. The difference creates an unfair advantage for anesthesiologists. No compromise exists on this issue because CAAs do not compete with anesthesiologists, only with CRNAs. With regard to whether it would be anti-competitive not to allow CAAs to work in the state, it was stated there would not be a fair playing field because anesthesiologists are not being replaced, only CRNAs. If CAAs could compete with anesthesiologists, creating a fair playing field and not furthering anesthesiologists' monopoly, there could be a compromise.

The opponents noted the addition of CAAs will hurt rural Kansas because 80 percent of Kansas facilities rely on CRNAs practicing independently. CAAs will also take jobs from CRNAs who want to stay in urban areas and force CRNAs to move to urban areas out of state.

The ACT model with CAAs would require additional anesthesiologists to ensure supervision requirements were met, making it more expensive than the CRNA model, which achieves the same outcome. A model with one anesthesiologist and three CRNAs would be less costly, and the providers would still be able to collaborate.

Committee Discussion

The Chairperson restated the Committee was looking for compromise agreeable to both sides to move forward with the legislation.

During Committee discussion, a Committee member proposed a compromise lowering the anesthesiologist-to-CAA ratio from 1:4 to 1:3 in the counties included in the amendment offered in the Senate Committee on Public Health and Welfare, with the possibility of lowering the ratio to 1:2 if the bill were expanded to include more counties. This proposal could also be expanded to the marketplace for CRNAs. The Committee member stated the intent is to move the legislation forward.

Conclusions and Recommendations

The Committee generally agreed the interested parties should attempt to resolve any issues or conflicts identified during the meeting and present an acceptable compromise during the 2020 Session.