Health and Human Services Committee
Topeka, Kansas 66612

February 14, 2019

Chairperson Brenda Landwehrand and honorable members of Health & Human Service Committee:

My name is Larry Finley and I am a Certified Registered Nurse Anesthetist (CRNA) in Emporia, KS and President-Elect of the Kansas Association of Nurse Anesthetists (KANA). I am writing in opposition to HB 2295 Anesthesiologist Assistant (AA) Legislation.

I am not going to disparage AA quality. There is no evidence to prove that AAs are equivalent or that they are better or worse than CRNAs. Why? Because, you can not compare apples to oranges. The only comparison you can make is between AAs and CRNAs that have allowed their practice to be minimized into a dependent provider rather than the independent provider they are trained and licensed to be.

I agree there are differences in the training programs of all three anesthesia providers. In reality, there are many different ways to train an individual to provide anesthesia and every provider believes there way is the best. Ultimately, it should be recognized that there are several different acceptable routes to the head of the table to take care of patients.

The limitations I do want to point out comparing AAs to CRNAs are specifically that the AA must be medically directed. This medical direction is regulated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rules that require the MD Anesthesiologist (MDA) to be present for the start and stop of anesthesia and be available for crucial times during the anesthetic. The problem with medical direction of one MDA to four AAs is it forces practices to commit Fraud.[1] The reason for this is that AAs can only work in a dependent medically directed anesthesia care team (ACT) model. Their limitations of not being independent providers encourages fraudulent billing by not complying with the TEFRA guidelines for medical direction. In contrast, CRNAs can bill independently using a QZ non-medically directed modifier even in ACT practices. As a result, practices stay compliant with billing rules while the very expensive, valuable services of the MDAs are freed up to benefit the patients and hospital systems rather than needlessly directing competent independent CRNAs. When practices maximize this legal ACT model, the anesthesia shortage is alleviated by not forcing the 4:1 medical direction ratio that ties up our valuable MDA colleagues with menial tasks.

QZ non-medically directed billing and the avoidance of medically directed TEFRA (required for AAs) rule violations will save the healthcare system costs by providing anesthesia in a more efficient manner by lowering anesthesia group subsidies from hospitals (both public and private). Dependent AA providers would only proliferate inefficient practices and increase healthcare costs with unnecessary redundancies.

Kansas is an opt-out state for medical direction and supervision of CRNAs. Therefore, CRNAs are not limited in any manner and provide exceptional quality of anesthesia care to the majority of patients statewide. The Federal Government has not allowed this same opt-out for AAs. The Military does not use AAs in their Military Anesthesia Teams and even Medicare will not reimburse AAs at the full rate because they must work under the medical direction of an MDA that is forced to try and comply with the onerous TEFRA rules which ultimately exposes them all to the possibility of fraudulent billing consequences.

In conclusion, I am a free market person. If you see fit to allow these limited dependent providers to come into Kansas, I am certain that CRNAs will be successful based on their greater flexibility, greater utility and lack of the need to be medically directed mitigating the risk of fraudulent billing.

REFERENCES:

1. Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics. Anesthesiology. 2012;116(3):683-691.