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AA'S ARE NOT A COST-EFFECTIVE PROVIDER FOR MICHIGAN

HB 4832 to license Anesthesiologist Assistants is not good for Michigan.

Historical perspective, AAs were created in 1969. There were only two programs in the United States (Ohio & Georgia). There was a lack of support from the American Society of Anesthesiologists and even through 2023 there are only 2,987 AAs educated and working in the U.S. in only 15 states and the District of Columbia. In 50 years, there are less than 3,000 AAs.

Louisiana has passed legislation that has the effect of prohibiting AAs from practice declaring that "CRNA's receive a much higher level of education and training than do AA's"[1].

> Per Louisiana[1]:
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> **(j)** Anesthesiologist assistants (AAs) are not presently authorized to train or practice in Louisiana and are only recognized in eight states.
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> **(k)** Less than six hundred AAs exist in the United States while over thirty thousand CRNAs are licensed and authorized to practice in every state in the United States.
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> **(l)** CRNAs receive a much higher level of education and training than do AAs.
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> **(m)** After thirty years of existence, only two AA schools exist in the United States while there are ninety-nine CRNA schools.
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> **(n)** CRNAs are trained and legally authorized to administer all types of anesthetics in all settings while AAs are limited by the type of anesthetics they can administer and the settings in which they are authorized to perform their services.

Comparatively, there are over 62,000 CRNA's that practice throughout all 50 states, Guam, and Puerto Rico. There are 42,262 physician anesthesiologists in the U.S.[2] Not all of these physicians are board certified; whereas, all 62,000 CRNA's are required to have board certification. In fact, 3,008 CRNA candidates took certification boards in 2023. There were 3,300 new Registered Nurse students enrolled in nurse anesthesia programs in 2023.

In Michigan, based on 2022 data "Physician Compare National Downloadable" file, there are 3,174 CRNA's and 1,499 physician anesthesiologists billing Medicare Part B. The data does not represent anesthesia provider types working within the Veteran's Administration or rural hospitals electing cost-based reimbursement under the Medicare Part A nurse anesthesia exception.

There are over 137 accredited nurse anesthesia programs in the United States utilizing over 2,300 clinical sites. In Michigan, there are five accredited programs: Oakland University, Wayne State University, University of Michigan, University of Detroit Mercy, and Michigan State University. These five programs are projected to graduate over 121 CRNA's per year by 2026. In 2023, 118 CRNA's were produced through these five programs. The anesthesia provider "shortage" projected in 2017 has been narrowing with the gap significantly closing in 2027. This has been in most part due to annual workforce studies and strategies through CRNA education and certification to produce full- service, autonomous practice providers.

Physician anesthesiologist first year ACGME residents and fellows has grown only 5.9% from 2016-2021.[4] Enrolling in 2021, 1,863 physicians to become anesthesiologists by 2025. Physician education and training is dependent on federal government funding.

No generalizable peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes. In contrast, the excellent, safe anesthesia care that CRNA's provide and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals.[3]

Because of the extensive training and education, CRNAs are permitted by federal and state law to provide every type of anesthesia service to patients *without* the involvement or presence of a physician anesthesiologist. Numerous research studies in the last 20 years confirm the quality and safety of these anesthesia experts.

- In contrast, AAs are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "under the supervision of an anesthesiologist", according to the American Academy of Anesthesiologists Assistants (AAAA).
- It is virtually impossible to assess the quality and safety of AAs because they cannot work apart from anesthesiologists.
- Therefore, comparing CRNA education, training, licensure, and safety to AAs, it is clear that CRNAs are the preferred anesthesia provider option with regard to preparation, flexibility, patient access to care, safety, and cost-effectiveness.

In May 2013, the Center for Medicare and Medicaid Services (CMS) clarified and confirmed that AAs are prohibited from billing Medicare for non-medically directed services (billing code QZ). This is in contrast to CRNAs, who are authorized to bill Medicare directly for non-medically directed services. CMS clarified the distinctions between CRNAs, who may practice autonomously, and AAs, whose must be medically directed by and anesthesiologists in order to bill Medicare. This action confirms what we already know: CRNA and AA educational preparation and services are not the same, and Medicare recognizes them differently.[5]

AAs do not offer any flexibility as a provider – the TEFRA medical direction rules must be met any time an AA is utilized. Without flexibility delayed starts and fewer surgical cases completed per day add more cost to the system[6]. AAs are eliminated from being part of the solution of improving access to care in underserved areas, and could cost a practice significant revenue due to AAs inability to expand access to care as needed.

- There are 34 Critical Access Hospitals (CAH's) including 10 in the Upper Peninsula and 24 in the lower peninsula (taking into account the two recent closures of Aspirus Ontonagon Hospital and Corewell Health/Spectrum Health Kelsey Hospital).
- There are 31 inpatient hospitals with CRNA only anesthesia delivery models in Michigan.
- Georgia with over 1,045 AAs requires 2,009 physician anesthesiologists while also having statistic of a high CAH closure rate.[6]

Medicare fraud is a constant threat with AA practice since they must be billed under medical direction for maximum revenue generation.

- The civil fines are up to three times the amount of damages sustained by the government and an additional charge of up to $21,563 per false claim.7,8
- Facilities may also be culpable of Medicare fraud for not assuring appropriate medical direction of AAs.
- The Journal of Anesthesiology printed a research article on the alarming lack of attention in following required medical direction rules resulting in Medicare fraud found 35% of the time in a 1:2 ratio of medical direction.7
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Costs of subsidizing a subservient limited ability provider with revenue guarantees to maintain the most expensive anesthesia delivery model. This is a significant line-item expense not sustainable by facilities already having significant economic pressures in an uncertain healthcare environment. These additional costs and high probability of Medicare fraud put both anesthesia practices and facilities at risk.

A deleterious effect on the education of our future autonomous CRNA providers if AAs are licensed in Michigan. Autonomous CRNA providers staff over 31 inpatient hospitals in qualified rural areas of Michigan. CRNAs take their foundation as critical care RNs and build their knowledge with clinical experiences in Level 1 & 2 hospital settings around the Michigan. AAs will displace the clinical education of SRNAs leading to a crisis in rural Michigan facilities.

Not an autonomous provider. Hours of clinical experience of new AAs are 2000-3000 compared to CRNAs 9000. AAs require no previous healthcare experience prior to AA school.[8,9] This leaves a large gap in clinical capability, skill, experience, and astuteness in caring for Michigan's residents. In comparison, CRNAs have earned a bachelor's degree in nursing and accrue on average 2.5 years of critical care experience before being admitted to a nurse anesthesia educational program. Thus, AAs require significant guidance and close direction during the administration of anesthesia and cannot work autonomously.

- Texas Christian University has a bridge program that allows AAs to transition into CRNAs during an additional 29-36 months of education. This is because AA training and education is NOT equivalent to that of a CRNA.[10]

In sum, CRNAs are far better qualified to provide quality anesthesia services than AAs. CRNAs are better prepared, have a superior breadth of healthcare education and clinical experience, and can be utilized more flexibly. There is no comparison between CRNAs and AAs in terms of education, experience, history, ability to work without anesthesiologist direction, recognition by surgeons, and presence as the predominant anesthesia provider in the military. Particularly in a time of rising healthcare costs and scarce resources, legislating AAs will only lead to decreased efficiency and lack of flexibility to meet not only operating room demand but also Michigan's access to safe, cost-effective anesthesia care. It is in the best interest of Michigan's healthcare system to prepare more CRNA's, not AAs.

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[3] See https://www.aana.com/advocacy/research/research-and-publications. See also "The Future of Anesthesia Care Today" site, available at http://www.future-of-anesthesia-care-today.com/.

[4] https://www.aamc.org/data-reports/workforce/data/percentage-change-first-year-acgme-residents-fellows-specialty-2016-2021.

[5] See CMS Policy Transmittal #2716 dated May 30, 2013, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf

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