The MacKinnon Brief on Anesthesiologist Assistants (C-AAs) (2/2019)

AA History, Programs, Certification & Recertification

Relevant History

- First AA programs opened in 1968 @ Emory (GA) and Case Western (OH)
- First Graduates were in 1970, 48 years ago.
- ASA did not take an interest in AAs until 2000/2001
- Prior to the ASA getting involved there were 300 practicing and only 2 schools

Number of AA Programs

- 12 Programs including satellite campuses
- Case has 3 satellites (Cleveland OH, Houston TX, Washington DC)
- Nova South East has 2 (Ft Lauderdale FL, Tampa FL)
- Multiple in beginning process to get into new states

Relevant Program Info

- Range in length from 24-29 months all confer a masters degree
- Shadowing experience is "preferred" but not required
- No previous healthcare experience required
- No specific entry degree required
- General pre-med classes required but not at every program
- GRE or MCAT required at some but not all and no specific score required
- Minimum of 2000 clinical hours*** (see below '2000 hour myth') ***
- Min. 63 curriculum hours
- "Supported" by a medical school and MDA residency program which does not even have to be in same state
- Rotate 2-4 week rotations in different sub specialties in some programs do not rotate
- CAN TAKE CERTIFICATION EXAM 180 DAYS (6 months) BEFORE GRADUATION

The 2000 Hour Myth

- AA students count every hour they are in hospital and simulation lab as "clinical hours"
- This also includes: learning to take physicals, taking patients histories, ACLS, PALS and BLS classes
- CRNAs have traditionally only counted hours actually performing anesthesia. Counted the same way CRNAs would have over 8636 Hours.

AA Re-Certification

- Need 40 CME hours every 2 years
- Must take recertification exam every 6 years

AA Workforce, Employment Options & PA Question

How Many AAs and States They Work In

- Currently just over 2000 in practice
- As of 2015 there were 219 graduating per year
- The majority of AAs as of 2016 are in GA (800), FL (225) and OH (221)
- AA can practice in 18 jurisdictions. 14 states in law by licensure, 2 by delegation and District of Columbia and Guam.
- Delegated authority adds increased liability risk for the MDA and the facility

AAs the Military and the VA

- AAs cannot practice in the military at all
- AAs can only practice in the VA under direct supervision and have a lower GS classification making their salary range from 56K-73K max. Hence no AAs in the VA.

AAs are NOT PAs

- The AAPA Stated (**http://tinyurl.com/y9rupb2f**):
- ***"The only similarity between AAs and PAs is that we are both are supervised by physicians and have the word "assistant" in our professional titles"***

Additional AA Facts

- AAs may practice without certification unless required by employer or state law
- Medicare does NOT require AAs be certified or re-certified to be reimbursed for services

• There is one PA->AA bridge program at emory which gives Pas 3 months of advanced standing making the program 24 months long.	
Evidence for AA Practice: 2 "studies" ASA/AAAA Point to	
2007 Kentucky legislative commission report	***OHIO "STUDY"***
• The "Ohio" study at University Hospitals of Cleveland. Supposedly compared AA and CRNA safety records over four years, from 1999 through 2003 • *KENTUCKY "STUDY" Conclusion:* ○ "No studies have been published in peer-reviewed journals assessing the impact of anesthesiologist assistants on patient safety … Overall, the lack of data limits the conclusions that can be made about patient safety outcomes for anesthesiologist assistants." http://www.lrc.ky.gov/lrcpubs/RR337.pdf • AAs suggest this means there are no studies showing they are not AS SAFE as CRNAs.	• Not a published study. • It was an internal data review at University Hospitals of Cleveland, the primary clinical affiliate of Case Western Reserve University (where one of the original AA educational programs is located) • NOT randomized for severity of cases • Would not release data analysis as it was part of an internal quality assurance process • No indication of the role or level of involvement of an MDA in each case • NOT peer reviewed, and primary author stated: • *"The review wasn't a carefully designed scientific study, said Dr. Howard Nearman, chairman of anesthesiology at both Case Western and University Hospitals."*(**http://tinyurl.com/ybltozd3**)
2018 Anesthesiology Study "Anesthesia Care Team Composition and Surgical Outcomes.'	

• **Only 5% of the administrative health claims were AAs**
  ○ The article reviewed 443 098 cases of which 421 230 were CRNA cases and 21 868 AA cases. CRNA cases represent 95% of the data and AAs only 5%. So in order to compare they had to use statistical models to extrapolate out the AA cases.
• **Concludes MDA involvement mitigates AA weaknesses**
  ○ The Epstein article also published in Anesthesiology shows that in a **1:2 ratio** the MDAs only meet the medical direction criteria 65% of the time and **only 1%** of the time in **1:3 ratio** meaning the MDA is **NOT THERE** or available to intervene with the dependent AA provider. (http://tinyurl.com/ya2t8h5g)
  ○ What if there is an emergency in 2 of the 4 AA rooms simultaneously?
  ○ What if an emergency occurs in PACU or Pre Op requiring the MDAs full attention?
  ○ What if all 4 AA rooms are 730 AM starts?
  ○ In order to mitigate these lapses in supervision which the article suggests is how MDAs eliminate the "systemic differences" with dependent AAs staggering start times would have to be employed considerably decreasing both revenue generation and case volume per day per OR impacting access to care. Additionally, this increases costs by requiring the same number of providers to do less cases which ultimately generates less revenue requiring even higher subsidies from facilities to maintain service. OR just use CRNAs.
• **Metrics studied are so general they cannot be applied**
  ○ Only focuses on inpatient mortality, length of stay and inpatient spending
  ○ Inpatient Mortality: Entirely focused on death. However, nothing in the article explains how death had anything to do with anesthesia services. There are many factors related to inpatient mortality not the least of which are surgical complications totally unrelated to anesthesia. Effectively this "study" says nothing as it does not provide the reasons for mortality. If the mortality related to anesthesia complications is higher in the AA population we would never know.	

- Length of stay: Presumably this metric was used to try and correlate anesthesia issues resulting in longer or similar LOS. However, they do NOT explain the reason for LOS. So, there is no way to know if additional LOS had anything to do with anesthesia care let alone CRNA or AA care.
- Inpatient spending: The increased costs of stay have no metrics showing the reason why they had increased LOS. How can we know if that had to do with anesthesia or not?

- **Metrics NOT STUDIED which ARE relevant**
  - Anesthesia specific complications, mortality, morbidity or MDA need to rescue/intervene
  - How can we know the impact of providers if we do not study ACTUAL anesthesia complications? How can we know the involvement of MDAs if we do not have an accounting of 'need to rescue' calls from AAs compared to CRNAs? How can we compare at all when we have NO IDEA the involvement of the MDAs in each case?
- **Did not control for supervision ratios, case acuity or MDA intervention/Involvement**
  - The article does not control for supervision ratios at all. This means AAs could be 1:1 and CRNAs could be 1:4 but there is no way to know. If AAs are supervised much closer it is effectively no different than the MDA performing the anesthetic but at a significantly increased cost. The evidence has shown CRNA only and MDA only care is equal.
  - Without controlling for case complexity and case assignments how can we make any statements on capability? What if all the CRNAs got the hard cases with sick patients and the AAs mostly got easy cases?
  - If the MDAs are constantly intervening and rescuing dependent AAs but not CRNAs then there is clearly more risk to patients particularity in light of the Epstein article lapses in supervision previously mentioned.
- **Ignores Cost-Effectiveness of QZ CRNA models which dependent AAs cannot function in.**
  - **Collaborative Models:** CRNAs can work in collaborative models with MDAs where there can be an unlimited MDA:CRNA ratio or where MDAs and CRNAs are all in rooms doing their own cases. This expands access to care and bends the healthcare cost curve.
  - **CRNA Autonomous Models:** CRNAs working autonomously with surgeons lowers costs of anesthesia delivery with same high-quality care/outcomes without providers who add no value but increase the cost of services exponentially.
  - These models are already happening across the country and it is questionable why the ASA would promote a model which does not expand access to care or decrease anesthesia delivery costs except for the purpose of maintaining monopoly.
  - AAs cannot work in ANY of these models as they must ALWAYS work under the supervision of an MDA thereby always generating revenue for them.
- **If MDA presence makes all the difference what happened with inpatient mortality?**
  - The article suggests that MDAs presence mitigate mortality yet the inpatient mortality rate was 1.6-1.7%
  - Either they were not there or their presence did not matter
  - The Epstein article clearly shows they were **NOT** there 35% of the time in a 1:2 ratio and 99% of the time in a 1:3 ratio.
  - Why are they getting paid 50% of each case if there is no value added or improvement in outcomes?

ASA Strategies
2018 saw 7 states introduce AA legislation (all defeated)

- Replace CRNAs with providers they can control ERGO: Control reimbursement
- More AAs = Less CRNAs = Less AANA/State members to fight legislatively (opt out, statute battles etc)

- Open satellite programs in states where there are no AAs to begin normalizing them followed by legislative attempts to bring AAs to the state
- Every state which allows AAs makes it easier to get into next state
- Keep introducing AA bills in a state until legislators get sick of hearing it or more Pro-AA legislators come on and it eventually passes

• ASA President in 2016 said: ○ ***"The ASA is committed to expanding Anesthesiologist Assistant practice across the country….. supporting state organizations submitting AA bills, opening new AA programs…"***	• Bringing AAs into a practice eventually causes the CRNA to become "normalized" to their presence and see them as 'friends/colleagues' resulting in less interest to fight against "their friends/colleagues"
Practices are stating they do not have enough employees ○ They claim they cannot get CRNA employees so they NEED AAs. This will be used as a reason to legislators, hospital administrators and surgeons that the additional provider is needed (AAs). ○ What they neglect to mention is that these practices often pay well below national average for CRNAs, cut benefits, have horrible practice environments and THAT is why they have high turnover and cannot get employees. ○ In any other market they would be forced to the negotiating table and review their practices and costs. However, in markets where there are AAs who previously worked at McDonalds making WELL below market value is a HUGE step up for THEM. • The key to battling this is simple supply and demand. It is eminently BAD business to alienate an employee supply of 50K CRNAs in favor of 2K AAs.	
Bring in AAs for other local states who are native to your state (born there) and want to "come home" ○ This is an attempt at sympathy from legislators who generally want to keep resources in their own state and professionals from migrating out of state because of regulations ○ However, the impact of bring in AAs will be to decrease the CRNA pool both in the state as well as at practices which adopt them. CRNA won't want to work there, exacerbating the shortage issue ○ Additionally, every dependent AA job is one less INDEPENDENT practitioner job (CRNA or MDA) in your state. • The key here is that there are already two pathways to "come home", MDA and CRNA. The state does not benefit from dependent providers and will lose independent ones by bringing them in thereby decreasing access to care and increasing costs.	

STRATEGIES FOR STATES (Best in RED)	
What does **NOT** work with legislators	
• Disparaging AAs (we look petty) • Saying AAs are "unsafe" (no evidence to back the claim) • Saying you don't want them to take CRNA jobs (anti-competitive, Trade Protectionism) • Saying AAs have less "education" ergo "not as good" = ASA argument against us • Do not frame as a turf war, legislators hate turf wars	
Fight AA Bill Every Year	**Point out Fraud risk**
• May not work forever as legislators get sick of hearing about it and may eventually pass it • Very Costly • Members increasingly get tired and aphetic about same fight every year • Likely will pass eventually as long as the ASA backs them	• ASA Epstein study (http://tinyurl.com/ya2t8h5g) • In a 1:2 ratio 35% of the time TEFRA rules not followed under medical direction • Likely > 70% in 1:4 • To avoid fraud = 1:1 ratio which is fiscally impossible • To avoid fraud = delay cases = less cases per day = decreased access for patients with same costs (OR still there now less efficient)

	• Fraud risk isn't just with anesthesia group, hospital may also share in risk or be investigated • CRNAs can bill QZ without requirements of Medical Direction (7 TEFRA Rules) and therefore no risk of fraud. AAs cannot do this.
Limit AA ratio (1:2)	**Require an AA to also have an additional healthcare license (PA or RN)**
• Less costly fight if you know they will win in that year • Increases the number of MDAs required as long as its clear an MDA can ONLY direct 2 AAs at a time not 2 AAs and 2 CRNAs in the statute • Still a fraud risk • SC, CO and NM have limited ratios (1:2, 1:2 and 1:3) but it has been overturned in other states such as florida	• Can be an addendum to the bill • Argument is that all other anesthesia providers have a license (MD/DO, RN, DDS) before anesthesia training so why lower the standard in your state • Result would limit AAs who can come to the state significantly and increase their costs (having 2 professions to obtain and maintain) • This was done in Kentucky in 2006 requiring an AA to be a PA prior to working in KY and the result is today there are no AAs in KY
Outlaw AAs via Legislation • Eliminates the problem entirely • Extreme resistance from ASA and AMA • Successful in LA in 2004 but they gave up opt out to do so • Unlikely to be successful in today's political climate	
Strategy for AA School Opening in NON-AA State	
• Determine if intended school has nursing program and interface with nursing dean to consider a CRNA program instead • Talk to provost/dean and explain the controversy this will cause for the school	• Contact BON and use AANA statement about CRNAs NOT teaching AAs and get a similar declaratory opinion
Convincing BON CRNAs Cannot Train AAs	
• Use AANA statement that CRNAs cannot train AAs • Likely anti-competitive argument will get little traction with BON • Argument will be used that CRNAs train SRNAs, medic and med students but this is different • Focus needs to be on delegating "anesthesia practice" • We can train physician residents because they have their own license and we are not delegating • We can train med students and medics because they never make clinical anesthesia decisions and ONLY are taught skills/tasks (intubation) in an episodic fashion • We can train SRNAs because they have an RN license during a program can have CRNA responsibilities delegated to them by MDA and CRNAs • MDAs can delegate to nearly anyone • CRNAs do not practice on delegated authority • AAs can ONLY be supervised by an MDA • AA students cannot be delegated anesthesia management functions by a CRNA	
Bring in Rural CEOs to Testify	
• Rural CEO is a third party who can testify to the increased cost of an ACT practice and why they don't have one • Stresses that it is not ok for people who are in labor or need surgery to have to drive hours for care (decreased access) • Stress that the CRNA only model is equal quality and cost effective allowing expansion of access to care • Can stress that losing independent practitioners for dependent ones hurts rural hospitals' as independent CRNAs leave the state decreasing the pool of rural CRNA potential employees	

Bring in Program Directors to Testify

- PDs can testify to the difficulty as it is to obtain clinical sites for RRNAs.
- Every AA student is one less CRNA student slot
- Many large urban facilities not taking significant number of CRNA students or none for political reasons and this will only worsen with AAs
- AAs cannot train CRNA students as they are dependent providers
- Impacting an already existing and successful independent provider educational program will only harm access to care and worsen any supply vs demand issues.

Medicare Beneficiaries RAPIDLY growing and Live EVERYWHERE, Cost increasing, those paying in are decreasing (Also the answer for MDAs saying AAs won't cause CRNAs to lose jobs "study")

- We should never use the argument that AAs coming in could cause loss of CRNA jobs, that is anti-competitive and not a valid argument (even if it may be true). We should focus on COSTS and ACCESS
- It is estimated that between 2010 and 2030, the older population (persons ages 65 and over) as a share of the total population is projected to jump from 13 percent to 20 percent (MEDPAC, 2015 report http://tinyurl.com/y46tnxel)
- In 11 years, Medicare is projected to have over 80 million beneficiaries—up from 54 million beneficiaries in 2015— almost 90 percent of whom will be of the baby-boom generation.
- The number of workers per beneficiary is rapidly declining. Workers pay for Medicare spending through payroll taxes and income taxes. However, the number of workers per Medicare beneficiary has declined from 4.6 during the early years of the program to 3.1 today and is projected by the Medicare Trustees to fall to 2.3 by 2030
- More beneficiaries getting surgeries with fewer contributing means a real fiscal crisis
- Medicare beneficiaries live EVERYWHERE not just urban centers with university medical centers.
- So the key is expansion of INDEPENDENT providers who are cost effective and capable, not DEPENDENT ones who not cost effective and cannot expand access, the answer is CRNAs

Additional Strategies

- Require in statute AA students be 1:1 with an MDA
- Prohibit CRNAs from teaching AA students with AANA AA statement (**http://tinyurl.com/yd5xrrb4**) and requested state board of nursing declaratory statement prohibiting it.
- Limit what facilities AAs can work at (NM made it so AAs could only be in Class A counties of 100K or more)
- Require AA specific public reporting of disciplinary actions which become public record
- Require language in statue which makes MDA 100% liable for all AA actions)
- Use workforce study and state demographics to show no shortage of providers
- Frame the ASA as attempting to create a physician monopoly as AAs are a tool to limit competition by their only real equals CRNAs. AAs can never compete against MDAs only CRNAs can. This drives costs up and reduces access to care (especially rural)
- State would have to spend money to license, regulate and monitor AAs with NO benefit
- Create a map of CRNA only and CRNA autonomous (no ACT) counties for legislators
- Get buy in from state nursing orgs, rural hosp assoc. and other entities (think tanks)
- Have grassroots connections with legislators BEFORE the fight comes to your door, BRING legislators into CRNA only practices to shadow to see we DO IT ALL alone.
- Get MD/DO/DDS/DPM supporters on board to write letters or testify
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AAs Can be Billed Medical Direction OR Supervision

AA Billed Medical Direction (QX/QY)	AA Billed Supervision (AD)
• Must be in a 1:4 ratio • Must meet 7 TEFRA rules	• No ratio (can be 1 MDA for ANY number of AAs or CRNAs)

• High risk of fraud (see fraud risk above)
• Individual AA NPI bills 50% of each of the 4 cases MDA bills other 50% of 4
• Still the second most expensive model after MDA only
• Limits Access to care due to inflexibility
	• NO TEFRA requirements ergo no risk of fraud
	• Individual AA NPI bills 50% of each of the 4 cases
	• MDA however can only bill:
	  ○ 3 units per case no matter how many units
	  ○ OR 4 units if they are also there for induction
	• This means money is lost on any case with more than 6 units (if MDA not there for induction) or 8 Units if there for induction when billing AD

What does this mean?

- MDAs could use AAs in any case less than 8 or 6 units and still get 100% of the fee
- Example: Colonoscopy 4 base plus 2 time units (30 min) means MDA could have AAs doing cases without any MDA involvement, but an EGD is 5 base plus 1-2 so the MDA would have to be there for induction to get 100% reimbursement
- In Academic centers where concern about anesthesia revenue is non-existent all AAs could be billed AD and the dept simply take the revenue loss (a drop in the bucket for these facilities)
- Could be used as a political tool against CRNAs and limit SRNA training
- Generally not worth it for private Anes. Groups or large AMCs due to potential lost revenue
- Some may take the hit for political gains/benefits against CRNAs
- Info Sheet on AD and QX/QY: **http://tinyurl.com/y97ppk8p**

Explaining Anti-Competitiveness of AAs to Legislators

- Use the "carpenter" example or "competing Groups" example.
- Say to the legislator / hospital administrator this:

"Imagine there was a magical tool that only one set of carpenters were allowed to use by manipulating the law. Using it made them more money yet they worked less for it than other carpenters. Would you agree that is anti-competitive?"

Or this example:

"If there are two competing groups, in the market. Both with excellent credentials. Both deliver a service. First group personally delivers the service and gets paid per case. The 2nd, hires others to deliver the services and can double their money by doing so. The former is not permitted the same advantage. Does this seem fair?"

ASA has lobbied for AA parity with CRNAs for years at the national level for equal reimbursement when supervising them, supervision ratios and then spent millions going state to state to obtain practice rights and remove barriers when there was no shortage of providers....why would they do that?????? Was the whole effort really to eliminate a class of providers and squash competition? Isn't that illegal?

<u>You could tailor these examples to things that would resonate with your legislator. Maybe they have a car dealership, they are hunters, they are golfers etc. Change the example to fit what they know.</u>

Now here is the reasoning expanded for YOU to better understand it:

- Free market allows for multiple carpenters to provide the same service. All trained in carpentry in different ways, yet they have the same quality product produced.
- All have the opportunity and access to use the same tools

- What then sets them apart is efficiency and cost effectiveness
- Imagine there was special tool which allowed one type of carpenter to work 4X as fast as others
- However only one carpenter gets specially granted access by the government to that tool and wants to deploy it everywhere to dominate the market
- Clearly the tool itself cannot compete with the carpenters as it cannot create on its own
- Clearly having this tool would be a competitive advantage for one group over others
- Yet because only one carpenter is allowed to use it created an anti-competitive environment
- This voids free market and limits the ability for others to compete
- AAs are the tool. They are not competitors for CRNAs or MDAs
- They are a specialized tool that legally can only be used by the MDAs
- Ergo: AAs are an anti-competitive strategy by the MDAs to go around the free market and create a monopoly.
- *CRNAs are not anti-competitive against tools. Remove the restrictions and allow CRNAs to supervise AAs the same way the other independent provider (MDAs) does and let the market decide.*