MINUTES

SPECIAL COMMITTEE ON HEALTH

October 21, 2019
Room 112-N—Statehouse

Members Present

Representative Brenda Landwehr, Chairperson
Senator Gene Suellentrop, Vice-chairperson
Senator Ed Berger
Senator Barbara Bollier
Senator Bud Estes
Senator Mary Jo Taylor
Representative Tory Marie Arnberger
Representative John Barker
Representative Eileen Horn
Representative Megan Lynn
Representative Jarrod Ousley

Staff Present

Iraida Orr, Kansas Legislative Research Department
Melissa Renick, Kansas Legislative Research Department
Marisa Bayless, Kansas Legislative Research Department
Eileen Ma, Office of Revisor of Statutes
Charles Reimer, Office of Revisor of Statutes
David Long, Committee Assistant

Others Attending

See Attached List.

MORNING SESSION

Welcome and Committee Overview; Introduction of Committee Members and Roundtable Conferees

The Chairperson opened the Special Committee meeting at 9:00 a.m. The Special Committee was assigned with studying the licensure of anesthesiologist assistants (AAs), including a review of 2019 HB 2295.

The Committee was joined by the following participants (listed by groups represented) in a roundtable discussion on issues surrounding the licensure of AAs:

- Kansas Medical Society (KMS):
    - Rachelle Colombo, Director of Government Affairs, KMS;
- Kansas Hospital Association (KHA):
    - Audrey Dunkel, Vice President Financial Advocacy, KHA;
- Anesthesiologists:
    - Eric Weissend, MD, Assistant Professor of Anesthesiology, University of Missouri—Kansas City (UMKC) School of Medicine and Children's Mercy Hospital;
    - Jessica Sweeney, MD, Assistant Professor, University of Kansas School of Medicine;
    - Greg George, MD, Anesthesiologist, President, Mid-Continent Anesthesiology Chartered; and
    - Patricia Powell, MD, Anesthesiologist, Ascension Medical Group; Medical Director, Ascension Via Christi St. Teresa and Founders Circle Surgery Center; Associate Professor, Anesthesiology, University of Kansas School of Medicine, Wichita;
- AAs:
    - Ty Townsend, Master of Science in Administration (MSA), Certified Anesthesiologist Assistant (CAA);
    - Julie Banderas, PharmD, Professor and Chair, Department of Graduate Health Professions in Medicine and Assistant Dean, Graduate Studies, UMKC School of Medicine; and
    - Jeremy Betts, Director of State Affairs and General Counsel, American Academy of Anesthesiologist Assistants (AAAA); and
- Certified Registered Nurse Anesthetists (CRNAs):
    - Larry Finley, CRNA, President, Kansas Association of Nurse Anesthetists (KANA);
    - Donna Nyght, CRNA, Program Director of CRNA Education Program, University of Kansas School of Health Professions, representing her own views;
    - Becky Lucke, CRNA, Wichita;
    - Bob Wright, Chief Executive Officer, Newman Regional Health, Emporia;
    - Charles Wilson, CRNA, Atchison;
    - Chris Jackson, CRNA, Kansas City, Missouri; and
    - Brian Fleeman, CRNA, Hutchinson.

The Chairperson provided a brief review of the agenda and asked the Committee members and roundtable participants to introduce themselves.

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

Eileen Ma, Assistant Revisor of Statutes, Office of Revisor of Statutes, provided an overview of 2019 HB 2295, which would enact the Anesthesiologist Assistant Licensure Act (Attachment 1).

Iraida Orr, Principal Research Analyst, Kansas Legislative Research Department (KLRD), presented a background summary of HB 2295 and information presented in the bill's public hearing. Additionally, background information was provided for 2019 SB 223 (similar legislation introduced on AA licensure), and AA licensure legislation introduced in 2017. During the Senate Committee on Public Health and Welfare hearing, there was discussion of amendments to SB 223, but no action was taken (Attachment 2).

Roundtable Discussion of Issues Surrounding the Licensure of AAs

The Chairperson provided the roundtable participants with the expectations for the roundtable and its purpose.

Opening Comments by Proponent of AA Licensure

Dr. Weissend provided an overview of the position of the certified anesthesiologist assistants (CAAs) seeking licensure in Kansas. He contended the licensure of AAs is an important step to provide Kansans with the best anesthesia services by increasing the number of anesthesia care providers and spoke to the advantages of licensure he has seen in Missouri. He described 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. He noted all efforts to reach a compromise with the CRNAs regarding the licensure of AAs have been rebuffed. He stated rural hospitals would not be required to implement an Anesthesia Care Team (ACT) model using CAAs (Attachment 3).

CAA Educational Requirements

In response to a Committee member's question regarding the educational differences between AAs and CRNAs, Ms. Banderas provided a summary of the educational requirements for AAs. The AA program 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 if the CAAs have the necessary education and training.

Mr. Betts responded to a Committee member's question, stating a master's degree is available for AAs but not a doctorate.

CRNA Educational Requirements

Ms. Nyght provided an overview of the educational requirements for CRNAs. Applicants 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 doctorate degree, with only one year left 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. It was noted 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.

Description of ACT Model

In response to a Committee member's questions about how the ACT works and the role of the anesthesiologist in overseeing the team, Dr. Weissend stated the preference is an ACT where the anesthesiologist is in supervisory mode and is required to be present for the beginning and end of all cases. There is strict criteria for being available in a matter of seconds. He stated, at Children's Mercy Hospital, the anesthesiologists try to limit supervision to two or three locations. The care teams can consist of CAAs, CRNAs, and anesthesia residents, with the supervising anesthesiologist rotating among the various locations as required to tend to the medical needs and able 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 Dr. Weissend commented is not a downside.

Dr. Weissend posed a clarifying question to Ms. Nyght regarding the additional year of training time required for the clinical doctorate degree. Ms. Nyght responded with details of the additional training received for the clinical doctorate degree.

Dr. Weissend stated the anesthesiologist is medically and ethically responsible for all actions taken by the care team.

Opening Comments by Opponents of AA Licensure

Mr. Fleeman stated he struggles with anesthesiologists in the supervisory role being able to manage a 3:1 or 4:1 CAA to anesthesiologist ratio, especially when CAAs would require direct supervision.

The Chairperson asked if there is a compromise in the CAA to anesthesiologist ratio.

Mr. Fleeman stated in response to the possibility of a compromise on the CAA to anesthesiologist ratio, from an anti-competitive standpoint as a business owner, he would take issue with introducing CAAs into an anesthesiologist practice in up to a 4:1 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.

Mr. Finley provided testimony regarding the expressed shortage of CRNAs in the state. He noted, at issue, is a shortage introduced at the University of Kansas Medical Center (KUMC) three years ago and the ability of a Missouri group to transfer staff across state lines to work at Children's Mercy and Saint Luke's hospitals in Kansas. He noted there is a healthy manpower demand, not a critical shortage. A study was cited ranking Kansas 12th best in the nation, with a CRNA to population ratio of 12:100,000. There is no CRNA shortage in Kansas. KANA has proposed an increase in CRNA graduates by 40 percent over the next three years to address the perceived demand. KUMC is going from 24 graduates to 30 per year in 2021 to 36 per year in 2022. Newman University in Wichita, Kansas, has the ability to expand its program from 20 to 25. Texas Wesleyan University also has 5 to 7 students studying in Wichita and Topeka (Attachment 4).

In-Depth Roundtable Discussion

Dr. Powell commented there is a severe shortage of CRNAs in Wichita. She stated she did not want to get involved in the issue of licensure of AAs because of threats from CRNAs that there would be consequences (if AA licensure occurred in Kansas). She spoke with every anesthesiologist group in Wichita and noted there is a need for 15 to 20 CRNAs or CAAs. The shortage has resulted in the shut down of operating rooms and a limitation in patient care.

Dr. Sweeney provided her view of supervising an ACT. There was a shortage of CRNAs two years ago at KUMC requiring the use of *locum tenens* (temporary providers) and CRNAs working overtime hours. With regard to the role of supervision by an anesthesiologist, there are always differences in the level of confidence between the team members. A new trainee may need more supervision, while others need less. The 4:1 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. She later clarified this was her experience working at Emory University Hospital with CAAs and CRNAs.

Dr. Sweeney stated she does not understand the concern with student AAs taking training spaces away from student registered nurse anesthetists (SRNAs). The COA requires training instruction and supervision of SRNAs only from anesthesiologists and CRNAs. If CAAs were introduced into the program, student AAs would be supervised by anesthesiologists and that should not interfere with SRNAs training in operating rooms along with all care providers.

In response to a question regarding the CRNA shortage situation in Wichita, Dr. Powell responded there are shortages at the Wichita facilities due to people leaving, retirements, and new facilities opening. She noted she is particular when hiring CRNAs because she wants to hire the best providers for her patients.

Mr. Townsend expanded on the analogy comparing ACTs to flying a plane. Everyone assumes the pilot is competent; no one asks where the pilot received training. The same holds true for ACTs. CAA 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.

Ms. Nyght provided clarification on the hiring of CRNAs at KUMC. The University of Kansas Health System hired only one graduate from the 2019 KUMC CRNA program and five or six total CRNAs in 2019 because KUMC hired 60 CRNAs over the two previous years. She observed there is no shortage of CRNAs at KUMC, and there is a current hiring freeze for CRNAs. She also clarified it is unacceptable for SRNAs to be trained in the operating room by anyone other than a CRNA or anesthesiologist.

Ms. Lucke disputed the pilot analogy by stating not all anesthesia providers have the same experience and skill level. She disagreed with Dr. Powell's assertion that it is difficult to hire CRNAs in Wichita. The clinic where Ms. Lucke works has the lowest pay in Wichita and always has a replacement hired and trained before someone retires or leaves.

Dr. George noted after a recent survey, Wichita is in need of 18 CRNAs and further commented there is a shortage of CRNAs in Wichita. Facilities are managing using residents and *locum tenens*. Efficiencies have been created, but there are no reserves. There is a concern after Newman University graduates its last CRNA class and moves to a doctorate program in a year or two, the issue will become critical as less CRNAs enter the market.

Mr. Townsend provided information concerning the history of the AA profession, which is celebrating 50 years. He described his background and training at Case Western University. He stated there is cross-training for AAs and CRNAs in areas where these professions have been working side by side for decades.

Dr. Weissend commented on the difficulty in hiring all ACT positions. The practice he works for has only been able to hire two CRNAs in the last two years, which is much less than needed. The question is what is best for the state. He stated a greater supply of providers is best if competent and safe, and AAs are safe. The licensure of AAs could eliminate hiring burdens, lower costs, and increase efficiencies.

Ms. Colombo clarified the issue being discussed in regard to delivery of care is a bill that would add CAAs to the ACT, not replace CRNAs. CAAs are asking to practice only under the direct supervision of an anesthesiologist as part of an ACT.

The Chairperson noted the AAs have completed the credentialing process, and the Special Committee is still discussing the topic. The Chairperson asked how the bill addresses the needs of both rural and urban health care.

Mr. Fleeman provided an example of a situation at Hutchinson Regional Health System several years ago when an anesthesiology care group demanded more money but did not receive it and left. If it were not for independent CRNA groups, the situation would have been difficult. He also provided information regarding billing, stating 75 percent of anesthesia billing was under the QZ modifier (CRNAs in independent practice).

The Chairperson stated there is no intent to eliminate CRNAs. She indicated the matter appears to be a turf issue, which is unacceptable when discussing health care. The Chairperson requested KLRD staff develop a flow chart with a side-by-side comparison of the schooling, training, and other requirements for both programs. A request was also made for the states

Kansas reciprocates with for CRNAs, with a list of the qualifications in those states, both similar and different. Additionally, the Chairperson requested employment numbers for the CRNAs and CAAs.

Mr. Finley stated the AA program would damage the established CRNA programs at KUMC and Newman University. He asked why only 1 KUMC CRNA program graduate was hired by KUMC in 2019, and the other 23 were not recruited by the Wichita facilities and left the state. Reference was made to a salary survey indicating pay is lower at the Wichita facilities. He stated the Wichita facilities should consider raising salaries to be more competitive. It was noted there is also a demand on a limited number of anesthesia providers in Wichita due to an increase in health care facilities.

In response to a Committee member's question, Mr. Finley responded hospital requirements determine how on-call staffing is handled. Ms. Lucke said her group of CRNAs is allowed to assist other facilities after the facility's cases are covered. She also described the use of *locum tenens* to fill staffing needs. Dr. Weissend defined a *locum tenens* as essentially a part-time position and noted the issue with these positions is the process of vetting and credentialing each person. Ms. Lucke stated it is sometimes cheaper to use *locum tenens* than to hire CRNAs and pay salary and benefits. Dr. Powell also stated *locums tenens* are expensive and credentialing makes using this staff difficult.

In response to a Committee member's question, Dr. George stated there are 15 to 20 unfilled positions in Wichita. Ms. Nyght stated KUMC has graduated 24 CRNAs each year. As a result of recent expansion, there are currently 24 seniors, 30 juniors, and 36 new students. KUMC intends to maintain the increased enrollment numbers as long as jobs are available for graduates. Sharon Niemann, Director, CRNA Program, Newman University, stated the current class has 20 students, with growth planned to 25 per year. The increase in student admissions is dependent on the availability of training sites, which could decrease due to a reduction in available training on high-risk cases if CAAs were allowed to practice in the state.

In response to a Committee member's question, Ms. Banderas said UMKC graduates 9 to 12 CAA students each year, but hopes to expand to 16. Some graduates are from Kansas and would like to return to Kansas. Some from Missouri would like to remain in Missouri, while students from other states would probably return home. The Committee member challenged why the numbers of graduates could not fill the need and whether the issue was control. Dr. Powell said control was not the issue. He noted one group loses six to eight CRNAs per year who go elsewhere after training, resulting in the constant churning of staff.

In response to the difference in a child's care at each Children's Mercy Hospital, Dr. Weissend stated the treatments varied between the two hospitals. Cases involving significant risk or rare or complex surgery are moved to the Missouri hospital because the Overland Park facility does not have an intensive care unit.

A Committee member stated Hutchinson Regional Medical Center would have been out of business when it lost its anesthesiologist if it had been staffed by CAAs instead of CRNAs. Dr. Weissend responded a federal rural pass-through law makes it almost impossible for anesthesiologists to operate at a rural hospital because anesthesiologists cannot receive full payment at critical access hospitals (CAHs) for services but CRNAs and CAAs can. He stated the federal law needs to be changed.

A Committee member recalled her personal experience as a participant in the KUMC scholarship program that paid the tuition for doctors who stayed in rural areas within the state. Due to exclusive contracts, she was unable to find employment in rural areas.

In response to a Committee member's question on how the addition of CAAs in the workplace would effect rural Kansas, Mr. Fleeman referenced a map of locations in the state where anesthesiologists practice (included in Attachment 4). He noted the majority of rural areas would not be able to use CAAs due to a lack of anesthesiologists and the cost of the ACT model.

In response to a Committee member's question, Mr. Finley stated CRNAs oppose the proposed amendment allowing CAAs to practice only in the four most populous Kansas counties because the CRNA's proposal to expand the number of SRNAs would cover the demands in Kansas.

In response to a Committee member question about whether there could be a compromise with the inclusion of other counties in the proposed amendment, Mr. Finley stated the CRNA plan to increase the number of graduates would cover the demand. He added, in regard to rural Kansas, the AA program would reduce the number of teaching sites needed to train SRNAs. Mr. Wright stated 87 hospitals in the state do not perform enough surgeries to financially support the ACT model.

Dr. George stated hospitals are not required to use the ACT model. CRNAs cannot say they are going to increase the number of SRNAs and also say there are not enough training sites for those students. He challenged a lack of available training sites. He stated there are more high-risk training spots in Wichita, but those spots are being denied. A handout provided reflected the growth in CRNA employment and wages (included in Attachment 3).

Dr. Sweeney addressed a Committee member's statement that the issue is quality and not quantity. She quoted a 2018 Stanford study of 400,000 Medicare cases that showed no outcome differences with regard to mortality, length of stay, and inpatient spending when comparing anesthesiologist led teams using CAAs versus CRNAs. Mr. Betts compared CAAs to physician assistants (PAs), noting the similarity in the undergraduate and graduate programs. He stated anesthesiologists are one of the few medical professions without an equivalent of a PA program in Kansas. Mr. Betts indicated raising salaries in Wichita to attract more CRNAs might pull those professionals out of CAHs, creating an even greater shortage in rural areas. Mr. Betts stated adding CAAs might curb the possible pull of CRNAs from rural areas. He stated there is no formal study documenting a reduction in SRNA training spots with the introduction of student AAs.

Mr. Finley brought up several points regarding training. 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 had to send SRNAs home for the day for a lack of a clinical instructor. He also commented anesthesiologists need CRNAs practicing independently, with most moving to the 'QZ' model. (*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.)

Dr. Weissend responded the Children's Mercy issue was a result of the inability to hire CRNAs because KUMC was hiring 30 plus SRNAs per year. One factor was KUMC's policy for several years promising CRNAs hired a strict eight-hour work shift. The policy was very

attractive to the students and caused many to chose KUMC over other hospitals that could not promise the set hours. KUMC's policy has since changed.

In response to the Children's Research Institute at Children's Mercy Hospital in Missouri requiring staffing with CRNAs and not CAAs, Dr. Weissand stated the issue is more about the hospital's physical plant. The obstetrics (OB) area 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 (billing for the services provided by a CRNA acting independently, without medical supervision).

Mr. Finley noted some CRNAs left Children's Mercy Hospital in Missouri because of dissatisfaction with the working conditions, including a reduction in their scope of practice to that of a CAA. Mr. Jackson provided comments about CRNAs not wanting to work at Children's Mercy Hospital. Dr. Weissend responded he did not feel the Committee meeting was the place to discuss the reasons Children's Mercy Hospital has difficulty in hiring CRNAs. He noted his group made a decision to hire CAAs, which was met with resistance from CRNAs and has likely played a role in the group's difficulty in recruiting CRNAs. He stated his group's model is very hands-on with regard to supervision, and some CRNAs may prefer a more independent role.

Mr. Fleeman addressed the issue of billing fraud by referencing the seven steps required by the Centers for Medicare and Medicaid Services (CMS) for Medicare compliance with regard to medical direction of CAAs by anesthesiologists. He stated noncompliance with the requirements is failed medical direction and billing fraud. He mentioned a study showing 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. He stated many compliance and regulatory issues exist in states that have enacted CAA legislation.

Mr. Betts clarified the billing fraud information provided stating 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.

In response to questions from the Chairperson, Mr. Betts stated 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. He believed the medical direction requirement was established in 1983.

Ms. Colombo provided clarification on the Kansas statute (KSA 65-1158c) that allows CRNAs to work as part of a physician-directed team but does not limit the number of CRNAs who can work on the team.

Ms. Nyght described the difficulty in locating clinical sites for those in the SRNA program at the University of Kansas School of Medicine. There is a strict minimum number of required specific categories of clinical experience needed to graduate. It is difficult to find clinical sites for

certain categories (*e.g.*, cardiac, OB, pediatrics, and neurology) due to the limitations placed by the various hospitals in the area as to the categories of clinical experience allowed. She noted senior students are sent to Fort Riley or Oklahoma for OB clinical experience, creating financial and emotional hardship for the students. She stated introducing student AAs will increase the competition for clinical sites and negatively impact available sites for SRNAs. Mr. Wilson provided his personal experience traveling long distances to SRNA training sites.

Dr. George questioned how the CRNA programs can increase student numbers to meet the need in Wichita if they cannot find training sites at the current enrollment level.

Ms. Nyght responded training sites are found to meet the clinical requirements, but the training sites are not available in the Kansas City area. In response to the availability of OB clinical sites in Wichita, Ms. Nyght stated the SRNAs need to be allowed to perform all of the required OB skills at the Wichita sites.

Dr. George stated many Wichita anesthesiologists are not in attendance to express support for AA licensure for fear their CRNAs who are opposed to AA licensure will quit in retaliation. With existing CRNA shortages in Wichita, he continued, anesthesiologists cannot afford to lose their CRNA staff.

Ms. Niemann, who was not a roundtable participant but was available to address questions regarding the CRNA program at Newman University, explained the limits to training sites. There are also limits due to anesthesiology residents being given priority for the same training sites needed by SRNAs.

Dr. Powell responded there is a limit on the number of SRNAs her group will accept, and the group no longer accepts residents. Her surgeons do not want to have students in the operating room because it slows the surgeries. With the ability to hire CAAs, she observed, while she may not hire them, she might have more or better access to CRNAs. She would like to provide more training sites, but her hands are tied.

Mr. Townsend stated traveling is an inherent part of clinical training because even the large hospitals cannot provide every clinical experience a student needs. Travel to clinical sites can provide invaluable knowledge gained from getting different perspectives and UMKC students, for example, travel to sites in St. Louis, Missouri, as well as Wisconsin, Ohio, and Oklahoma.

Dr. Sweeney stated there might need to be changes in the training program processes to allow SRNAs to train in the same room as student AAs in order to meet the clinical site needs.

A Committee member stated osteopathic programs require osteopathic students to find their own training sites and travel throughout the country for training.

Ms. Banderas addressed a previous comment made by a Committee member by stating one AA program cannot supply all the needs. If licensing were available, CAAs would come from other states. SRNAs may only be trained by CRNAs and anesthesiologists. Student AAs can be trained by CAAs, CRNAs, and anesthesiologists. Perhaps student AAs and SRNAs could receive training in the same room by a CRNA. There could be some turf wars at the beginning, but this would lessen over time as the groups become more familiar.

Mr. Fleeman stated student AAs will take up training sites. 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 2 Kansas CRNA programs are graduating 60 plus CRNAs per year, which is 3 times the number of CRNAs needed in the Wichita area. Texas Wesleyan University also has five to six students training in Kansas, some of whom may stay.

Ms. Nyght stated COA standards must be met to train CRNAs; CAAs cannot train SRNAs. CRNA schools must have contracts with facilities that provide training sites. The contract process can take 6 to 12 months.

A Committee member stated CRNAs are invaluable to western and rural Kansas. CAAs cannot help the situation in rural Kansas due to their scope of practice. CAA licensure would only apply to the larger cities and hospitals where higher patient loads are located.

Dr. Powell stated allowing CAAs to work in Kansas may help the rural areas. With regard to the reduction in SRNA training sites, she noted 2019 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.

Dr. Weissend noted a greater supply of anesthesiology providers can only benefit everyone. The issues are training locations and the supply of anesthesiology providers. A 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.

The Chairperson recessed the meeting at 11:56 a.m. and announced the roundtable would resume at 1:30 p.m.

AFTERNOON SESSION

Continuation of Roundtable Discussion

The Chairperson reconvened the meeting at 1:30 p.m. and noted the quality discussion, asking if there were additional points to be made and if there were areas of compromise.

Mr. Finley provided comments regarding his understanding of the morning discussion. He stated his belief that 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. He stated his communications with Wichita-based CRNAs do not validate a demand exists for 18-20 CRNAs in the area. There is a concern with CAAs needing 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 liability issues.

Mr. Fleeman restated his position on the anti-competitive nature of the proposed legislation. 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. The 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.

Mr. Betts stated CRNAs control the market because no other mid-level non-physician anesthesia providers are allowed to practice in the state. CAAs 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. CAAs would like to know if there is any compromise KANA and its members would accept to bring AA licensure to the state.

Mr. Fleeman responded CRNAs have provided the solution to the shortages with the increase in SRNAs. A question was posed regarding whether a CAA could compete with an anesthesiologist. Mr. Betts stated CAAs cannot and are not interested in competing with anesthesiologists. The question was restated regarding any scenario that would allow CAAs to practice in the state.

Mr. Fleeman responded, as a business owner, there is no compromise because CAAs do not compete with anesthesiologists, only with CRNAs. It would be anti-competitive to allow an anesthesiologist to have a 4:1 advantage over a CRNA with regard to the cases that could be worked in a day. With regard to whether it would be anti-competitive to not allow CAAs to work in the state, he 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.

Dr. Sweeney stated she understood the frustration in locating high-risk OB training sites for the current SRNAs. She noted she does not represent KUMC, and it is not within her power to provide high-risk OB training sites. She felt it was unfair for KUMC to not allow high-risk OB training spots for SRNAs but expect newly-hired CRNAs to staff the on-call high risk OB cases.

Ms. Nyght stated facilities cannot be forced to provide training sites, and training sites will be affected by the addition of CAAs. Ms. Nyght 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.

In response to a Committee member's question regarding who determines who can be trained at high-risk OB facilities, Dr. Sweeney responded she did not know the intricacies of that decision-making process. There has been discussion regarding high-risk OB training in her department's Executive Committee. Although she cannot speak for the department, she believes the hospital would take the recommendation of the department's Executive Committee. A Committee member requested staff research how the decisions regarding allowing high-risk OB training for SRNAs are made and if hospitals, anesthesiologist groups, or both make the decision.

Dr. Weissend addressed what he viewed as the improper use of the term "monopoly" in the discussion. Each hospital determines its own bylaws, and 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. He believed CMS rules required anesthesiologists to be in charge of anesthesiology services at hospitals, especially with regard to sedation, so hospitals' hands were tied. It is up to hospitals to determine how they contract. He stated the true monopolies were in rural CAHs, where anesthesiologists could not 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 a CRNA. He reiterated more providers of anesthesia services could only help all areas of the state. He stated the University of Kansas School of Health Professions CRNA program could not guarantee all SRNAs would stay in the state, regardless of a focus on enrolling Kansas residents.

In response to whether a CRNA could supervise a CAA, Ms. Colombo responded the introduced legislation would only allow a CAA to work under a licensed anesthesiologist. An explanation was given as to how CRNAs operate in the State of Kansas, with a comparison to the PA versus advanced practice registered nurse (APRN) model.

With regard to the liable parties in an operating room if wrongdoing occurs, Ms. Colombo responded multiple parties could be named in a lawsuit, but liability would depend on various factors including malpractice insurance coverage. CRNAs participate in the Health Care Stabilization Fund (HCSF) and have medical malpractice insurance. CAAs would likely be covered under the anesthesiologist's policy; even if CAAs would be named in a lawsuit, the anesthesiologist under whose supervision they practice would ultimately be liable.

The Chairperson asked whether CAAs should participate in the HCSF if legislation licensing AAs passed. Ms. Colombo responded, under Kansas law, one factor in determining the providers required to participate in the HCSF 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.

Mr. Wright noted CAHs in Kansas would not be able to afford the ACT model. This would not be a supply and demand issue because the majority of the 87 hospitals with less than 4 operating rooms could not have a 1:4 ratio. Dr. Weissend countered, with an additional supply of anesthesia care providers, there could be opportunities for more CRNAs to be available for rural communities.

Ms. Colombo noted no harm is intended for CRNAs or any hospital as a result of the introduced legislation. There is a need for a blend of provider types to provide all services needed. Quality should be protected. The goal is to grow the team to protect quality care for the patients.

Mr. Wright stated the ACT model with CAAs is 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.

Mr. Betts stated CRNAs do not want to work in ACT models unless they can work to the full extent of their training. Mr. Wright responded CRNAs do not disagree with operating in a collaborative way, but the concern is not being able to work to the extent of their training.

Dr. Weissend stated a set CMS reimbursement would be paid for anesthesia services and would be the same for either model. 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.

Ms. Lucke stated the ACT model can be catastrophic in clinics like hers with six surgical rooms if multiple emergencies occur at one time and the provider available cannot practice independently.

Dr. Sweeney stated a new model is not being introduced, rather the legislation provides additional options. She noted an advantage to having another care provider working alongside an anesthesiologist in critical situations.

Mr. Fleeman reiterated CRNAs pay into the HCSF at the same surcharge rate as an anesthesiologist, even in an ACT model. An ACT model with CRNAs is not limited to a 1:4 ratio. A six-room situation could be staffed using an ACT model with one anesthesiologist and CRNAs, but two anesthesiologists would be required if CAAs were used to staff. The new AA model would be more costly due to the need for additional anesthesiologists, who earn significantly more than CRNAs.

Dr. Powell noted the cost of medical malpractice insurance is different for anesthesiologists and CRNAs. Rural and urban health care are different models. In Wichita, the standard of care and the hospital dictate what the anesthesiologist will do. Sometimes the hospitals will dictate who the anesthesia group will be because the hospitals contract with specific groups.

In response to Dr. Powell's question as to why CRNAs would lose their jobs to CAAs, Ms. Nyght stated that has been proven at St. Luke's on the Plaza, Liberty Hospital in Kansas City, and a number of places in Missouri. Ms. Nyght stated she has been told by colleagues in Missouri that CRNAs are being replaced with CAAs, which has created a shortage in training sites. If CRNAs cannot be trained in Kansas, it would affect rural Kansas that depends on independent CRNAs. Dr. Powell responded she would never replace a CRNA with a CAA. Some CRNAs might become upset and leave if she brought in CAAs, but it would not be because she let the CRNAs go.

Mr. Wilson described his situation as a CRNA at St. Luke's Hospital that led him to leave. He noted having invested a lot of time, effort, and money to become an independent provider, but the scope of practice at St. Luke's Hospital changed to the point he felt unable to act as an independent provider. The CRNAs who left did not do so because of a toxic environment or a dislike of CAAs but because the CRNA role had changed to that of a dependent anesthesia provider. In response, Dr. Powell stated she restricts the CRNAs' scope and if they are dissatisfied, they can leave. That would not change if she hired CAAs.

Dr. Sweeney noted Mr. Wilson's departure filled a need that existed at the Atchison Hospital. Mr. Wilson responded his departure left a critical need that still existed but could not be met by CAAs. Dr. Sweeney stated it appears the additional CAA hires created an opportunity for a rural location. Mr. Wilson responded, in most cases, people in urban areas want to stay in urban areas and most would opt to move out of the area to another urban location.

Dr. George stated evidence does not suggest the introduction of CAAs has a negative influence on the numbers of CRNAs. He suggested a compromise to not establish a CAA school for five years.

Mr. Fleeman stated the original legislation (2017 HB 2046) was created to eliminate critical shortages of anesthesia providers. The addition of CRNA students has eliminated the shortage. In response to a statement by Dr. George that there has always been a shortage of CRNAs, Mr. Fleeman stated he has four CRNAs on staff and, despite being in a rural area, has always been able to fill any vacancy. He believes the problem is recruitment, not a need.

Dr. George stated the number of ads does not reflect the number of CRNAs needed. One ad could be for multiple positions. Mr. Fleeman stated he offered his services at Wesley Medical Center, where he is accredited, but had not received a response.

Mr. Townsend stated the purpose is to put together the best care team. He provided numbers from a Missouri study showing CAAs did not take jobs from CRNAs.

The Chairperson requested each side select someone to give a closing argument, following the comment from Ms. Colombo.

Ms. Colombo provided a basic overview of 2019 HB 2295. Currently, 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.

Mr. Finley stated there is no critical shortage of CRNAs. KANA believes licensure of CAAs would damage SRNA training programs. CAAs would be more costly due to the requirement for anesthesiologist supervision. The legislation would create an unfair competitive advantage, and there appears to be no possible compromise. The CRNAs' compromise would be to expand SRNA training spots, which has been done to eliminate future CRNA shortages. The best solution would be to keep CRNAs in the state and not force them to go elsewhere to practice to their full authorized scope.

Dr. Weissend stated the goal of the proposed legislation is to protect the citizens and provide the best possible service. The use of CAAs would not increase cost. The legislation would allow the hiring other qualified providers to fill anesthesia care needs. He noted it would be irrational to restrict proven health care practitioners being used in other states with an excellent track record, no medical malpractice issues, or issues of fraudulent billing.

A Committee member noted anesthesiologists provide the highest rated quality in patient safety. The American Association of Anesthesiologists would not subscribe to CAAs if they would, in any way, cause harm to patients.

A Committee member noted the Committee heard about efforts to eliminate what some perceive as a CRNA shortage. A question arises as to the best solution. Dr. Sweeney noted an anesthesia provider shortage will always exist and needs to be addressed to fully staff ACTs. She would like to have a large pool of qualified applicants from which to select.

Ms. Banderas, with regard to what limits on UMKC from increasing the number of CAA graduates to 30, responded she was participating only to discuss the quality of CAAs' training and to advocate for her CAA graduates who want to practice in Kansas. She is not advocating for increased AA training slots. She stated the number of AA students has increased slowly over time in part due to the availability of training sites. At the beginning of the AA program, not many hospitals were willing to train AAs due to CRNAs and anesthesiologists not wanting to broach

the difficult situation between the two professions. She stated UMKC student AA training slots are adequate at this time.

Ms. Banderas responded to a question about UMKC CAA graduates' ability to find jobs in Missouri, stating all UMKC CAA graduates receive job offers six months to one year prior to graduation. About 70 percent of the positions are in Missouri; the rest go out of state.

A Committee member asked about a patient's right to choose the provider of anesthesia services. Ms. Lucke responded her experience has been the patient is typically informed by the surgeon that there are CRNAs and anesthesiologists available. If the patient opts for an anesthesiologist, one is provided, but the procedure probably would be scheduled late in the day.

Mr. Finley asked if there is not a safety issue, why are CAAs only allowed in 17 states and there are only 12 AA schools. He stated no new CAA legislation had been enacted since 2014. CAAs cannot practice in the military. CAAs have existed for 50 years, but their practice has not evolved.

Mr. Townsend stated he has always worked as a part of an ACT. CAAs are a good product, and he believes the best model would have a mix of CAAs and CRNAs to provide a quality service. He noted not every state will have CAA licensure. He stated CRNAs have existed for over 150 years and CAAs for 50 years; it takes time to grow a program.

The Chairperson noted the discussion could continue with points going back and forth. She stated having been through many similar situations and this one, for no better description, is a "turf war." The Chairperson stated it has been disturbing to see one profession try to keep another profession from a care team. She noted patients assume their health care providers have put together the best team possible.

Discussion and Recommendations for the Committee Report to the 2020 Legislature

The Chairperson restated she entered the meeting not having made a decision on AA licensure. The Chairperson suggested the parties meet and arrive at an acceptable compromise.

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 expand the marketplace for CRNAs. The Committee member stated the intent is to move the legislation forward.

In response to a Committee member question, Mr. Betts stated the proposed legislation would not allow CRNAs to supervise CAAs. Federal law requires CAAs be supervised by anesthesiologists. Ms. Colombo agreed, stating it would be similar to PAs not being able to be supervised by APRNs.

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

The Chairperson directed staff to create a report that highlighted items from the roundtable discussion and indicated the Committee also would like to see a path for a possible compromise on the issue. Both sides were asked to seek a compromise solution for the 2020 Legislative Session.

Representative Ousley requested his opposition to the recommendation asking both sides to seek a compromise be noted. He indicated more time should be given to see if the additional CRNAs students would fill the need.

Adjourn

The Chairperson thanked the roundtable participants and staff for their time and effort, and adjourned the meeting at 3:10 p.m.

Prepared by David Long

Edited by Iraida Orr and Melissa Renick

Approved by the Committee on:

January 21, 2020
(Date)