November 28, 2022

Re: Opposition to the credentialing application to license Anesthesiologist Assistants in Nebraska

Members of the Credentialing Review Committee for Anesthesiologist Assistants:

The Iowa Association of Nurse Anesthetists (IANA) would like to submit this letter to the committee in opposition to the credentialing application to license Anesthesiologist Assistants (AAs) in Nebraska. IANA was successful in defeating legislation to bring AAs to Iowa in 2015 and again in 2016. The same conditions that lead to the defeat of previous AA bills remain today and are largely similar in Nebraska as compared to Iowa.

AA practice is not as prevalent and progressive as the supporters would like you to believe, especially in the largely rural Midwest. There are no AAs in Kansas and only 11 practicing in Oklahoma. Currently, there are approximately 3,000 AAs in the United States licensed in a total of 14 states plus the District of Columbia and Guam. AAs are allowed to practice by delegation in three additional states. Conversely, there are approximately 56,000 CRNAs licensed in all 50 states and highly utilized in the US Armed Forces.

Contrary to what the supporters have stated, CRNAs and AAs are not the same or interchangeable. CRNAs are educated to be independent providers and have the flexibility to work in any facility in your state that provides anesthesia services. The background of a CRNA requires critical care experience and a doctoral level education. AAs are not required to have a healthcare background prior to entering their anesthesia program. They are not required to be nurses, nurse practitioners (NP), or physician assistants (PA) to enter an AA program. AAs must be directly supervised by an anesthesiologist to practice, making them inflexible, dependent providers. So, while CRNAs have taken care of the sickest patients on life support and ventilators, honed their communication and critical thinking skills, perfected their clinical skills, and dealt with medical emergencies daily, AAs have pursued a dangerously narrow course of study. We are not the same.

Like Iowa, AAs do not increase access to surgical care in Nebraska. AAs must be directly supervised *only* by anesthesiologists, who work almost exclusively in urban areas. No rural or underserved areas would benefit from AAs, as these facilities are CRNA-only anesthesia staffed. Since CRNA vacancy rates have remained relatively steady in Nebraska over the last ten years, as outlined by the opponents, AAs in Nebraska would not help the “perceived” shortage of anesthesia providers. In fact, it would do the exact opposite and require more anesthesia providers at a higher cost to provide the same care.

Introducing AAs to Nebraska will increase healthcare costs for facilities and patients. AAs must bill in tandem with an anesthesiologist, therefore requiring two providers to bill for the administration of one anesthetic. This is a significant financial incentive for the contracted anesthesiologist groups, but hospitals are not likely to receive those same incentives. Requiring two anesthesia providers for one anesthetic, versus one CRNA who bills independently, increases healthcare costs to hospitals and their patients. The CRNA-only model remains the most economical model of anesthesia delivery. CMS does not recognize CRNAs and AAs as interchangeable providers, and AAs cannot independently bill for their services. Further, specific federal regulations, known as TEFRA requirements, must be followed to bill for direct supervision. These requirements are often not met when staffing at the 1:4 ratios proposed by supporters. This means that the supervising anesthesiologist may not be available to intervene during an anesthetic with the *dependent* AA provider. After all, how can a provider be in 4 rooms at once? Non-compliance with these requirements is considered federal fraud and may risk both patient safety and the hospital's ability to bill for anesthesia services.

Additional cost is inevitably associated with licensing and regulating a new provider category in a state. Expending state money to license and regulate AAs is not reasonable in a rural state with very limited locations for AAs to practice. For example, the State of Oklahoma, which has allowed AAs to practice since 2008, licenses and regulates a grand total of approximately 11 AAs.

CRNAs and anesthesiologists both have multiple large-scale studies looking specifically at CRNA and anesthesiologist safety and patient outcomes, showing no difference in outcomes whether the anesthesia delivery model is anesthesiologist only, CRNA only, or an anesthesia care team with anesthesiologists and CRNAs. AAs have no supported similar peer reviewed journal-published studies. The quality of care that AAs provide likely will never be studied if they continue to practice as dependent providers. There is no category to track safety for AAs in the National Practitioner Database as there is for CRNAs, PAs, and NPs. The safety and quality of anesthesia care that AAs provide is unproven.

Both CRNAs and anesthesiologists in Nebraska are highly educated and trained to provide quality, safe anesthesia care. Introducing AAs to Nebraska, as in Iowa, would provide no enhancement to your anesthesia services, with increased costs and potential safety risks. The Iowa Association of Nurse Anesthetists urges you to reject this proposal.

Respectfully submitted,

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President, IANA