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March 3, 2021

The Honorable Bronna Kahle,
State Representative and Chair,
House Health Policy Committee
Michigan House of Representatives

Dear Chairwoman Kahle:

On behalf of Kalamazoo Anesthesiology, thank you for the opportunity to share the following concerns regarding House Bill (HB) 4359, legislation eliminating physician oversight of Certified Registered Nurse Anesthetists (CRNAs).

Kalamazoo Anesthesiology (KA), founded in 1964, provides anesthesiology services, operating room management, and chronic pain management and consultation. KA serves Allegan, Barry, Van Buren, Kalamazoo, and Saint Joseph Counties, and has 150 employees ranging from front-line clinicians including physician anesthesiologists and CRNAs, to dedicated support staff.
Our practice is proud to be one of the largest private employers of CRNAs in the state. KA values and respects these highly skilled advance practice nurses.

Proponents of HB 4359 argue that more than forty other states allow the independent practice of nurse anesthetists, and that passing this legislation will increase access to care, decrease costs, and improve quality. Unfortunately, the evidence does not support these claims.

First, lack of physician oversight is NOT common practice: Only five states allow CRNAs to practice independently without any physician oversight or collaboration.

Eliminating physician oversight will NOT increase access to care: While there is a growing shortage of anesthesiology providers (both CRNAs *and* physicians) in Michigan and in the U.S., this bill does nothing to address that shortage. Michigan law does not require CRNAs to be supervised by anesthesiologists. The operating surgeon can fulfill that role. Consequently, hospitals that choose to, can well manage without anesthesiologists.

To improve rural hospitals' ability to attract surgeons who do not wish to be responsible for overseeing CRNAs, the Michigan Society of Anesthesiologists has in the past, proposed legislation to allow CRNAs at critical access hospitals to be remotely supervised by anesthesiologists. This is consistent with other telehealth innovations, such as remote monitoring of intensive care beds, and would increase the quality of care available in rural settings.

Another solution to the growing shortage of anesthesia providers (again, a shortage of *both* physicians and CRNAs) is for Michigan to consider the licensing of Anesthesiologist Assistants (AAs). AAs have master's degree training similar to physician assistants and administer anesthesia under the direction of anesthesiologists. They work as part of anesthesia care teams with anesthesiologists and, in states that recognize these providers, AAs are used in the same manner and settings as nurse anesthetists.

But most importantly, Michigan's health access problems relate to primary care and dental care, not anesthesia care. Simply put, Michiganders suffer from high rates of obesity, heart disease, smoking, diabetes, and pre-term births, not from a lack of anesthesia services.

Eliminating physician oversight will NOT reduce costs: Medicare, Medicaid and commercial insurance programs reimburse anesthesia services the same regardless of the provider delivering anesthesia care. That is because anesthesia services are reimbursed differently from other procedures. Anesthesia services are calculated based on the following criteria:

- Difficulty of the procedure
- Time
- Modifying factors (such as the health of the patient)

The general formula for calculating anesthesia charges is:
(Base units + Time units + Modifying units) x Conversion factor = Anesthesia charge

A notable exception is additional federal "pass through" funding available to certain rural hospitals for CRNA services. This provision is not applicable when anesthesia is provided by an anesthesiologist, so in this instance, Medicare pays more for CRNA services than the same service by an anesthesiologist.

It is also interesting to note that among Michigan and our five bordering states (OH, IN, WI, IL, MN), Michigan has the lowest per capita health care costs ($8055), while Minnesota, which allows CRNAs to practice with the most independence amongst the six states, has the highest ($8871). (Source, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0416)

Eliminating physician oversight will NOT improve quality: Quality of care is not improved by removing physician oversight. If considered as its own category, perioperative deaths would be the third leading cause of death in the United States (the leading causes prior to COVID-19 being heart disease, cancer, and COPD). Though CRNAs are skilled at providing anesthesia services, physician collaboration is needed for medical management of complications that commonly arise during the perioperative period (before, during, and after surgery). Decisions such as when to administer blood, what to do about post-operative chest pain, breathing problems, blood chemistry anomalies, and a myriad of other deviations from normal bodily functioning or operation, routinely necessitate physician evaluation and management before, during, and after surgery.

In summary, Kalamazoo Anesthesiology urges you and members of the House Health Policy Committee to vote "no" on HB 4359. Proposed changes to the current law will not improve the quality of health care for Michiganders and would likely have a negative impact on patient health and safety. Further, removing physician oversight will not reduce costs or improve access to care.

Thank you, Chairwoman Kahle, for your consideration of KA's views. If you would, please share a copy of our comments with members of the House Health Policy Committee. Please feel free to contact me with any questions.

Sincerely,

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