Melissa Croad, MSNA, CRNA, APRN
20 Riverview Avenue
Stow, Massachusetts 01775
Phone: 617-306-5305 ▪ Email: mpicceri@gmail.com

March 15, 2023

Testimony submitted for the Massachusetts Health Care Policy Commission Hearing on the Health Care Cost Benchmark

Thank you for the opportunity to provide some important information regarding cost-effectiveness in anesthesia practice models in Massachusetts.

Barriers to patient care provided by Certified Registered Nurse Anesthetists is costing Massachusetts millions!
Like other APRNs in Massachusetts, CRNAs are independent practitioners. There are no laws or regulations that require physician supervision for APRNs to practice. Regarding Prescriptive Authority, *An Act Promoting a Resilient Health Care System that Puts Patients First (the "Patients First" act[1])* was signed into law by Governor Baker on January 1, 2021. With its passage, APRNs are granted independent prescribing authority after a 2-year supervisory period by a Qualified Healthcare Practitioner (QHP), who may be another APRN or physician in the same or related clinical category.[2]

Even though there no laws or regulations requiring supervision of CRNA practice in Massachusetts, significant practice barriers remain. Barriers to CRNA independent practice are costing the healthcare system at large millions in savings.

A January 2022 report of Certified Nurse Midwives (CNMs) by the Health Policy Commission (HPC) found that facility culture, bylaws, and commercial payer policy are barriers to CNM practice. These barriers are similar to practice barriers that CRNAs face, perhaps in an even more pervasive and intense manner than that of our CNM colleagues. Practice barriers are extremely costly to the already strained healthcare system and are exacerbating the staffing challenges of anesthesia practices in the Commonwealth. [3]

Hospital Bylaws, Cultural and Perceived Liability Barriers
In almost every facility in Massachusetts, bylaws or departmental policy require that CRNAs are unnecessarily supervised by physician anesthesiologists, who provide little or no hands-on anesthesia care. Rather, they "medically direct" CRNAs and are available for assistance in a fixed ratio of CRNAs to physician anesthesiologists without consideration of surgical complexity and patient medical status. The majority of surgical cases performed today require only one anesthesia provider to care for a patient, and do not require additional assistance from another anesthesia provider serving in the role of "medical direction" supervisor.

Anesthesia practices whose physician anesthesiologists do not maximize their skillsets by personally administering anesthesia, and instead provide unnecessary "medical direction" for CRNAs results in duplication of services, as CRNAs and physician anesthesiologists can provide the same services. This unnecessary supervision decreases access to care, as the physician anesthesiologist, who could personally administer anesthesia does not, thereby decreasing the number of available anesthesia providers. This practice model is simply inefficient and certainly not cost-effective. The current financial state of healthcare systems in Massachusetts simply cannot sustain these expensive practice models that pay more providers than necessary to provide an anesthetic
.
Liability is consistently one of the most common concerns surgeons and hospital executives express about CRNA services. Anesthesia care provided by CRNAs does not increase liability for surgeons or facilities compared with physician anesthesiologists providing the same services.[4]

- **Captain of the ship;** the idea that a physician is responsible for everything that happens in the operating room, has never been used to win a liability case in the state of Massachusetts.
- **Vicarious liability** suggests a surgeon is responsible for another's acts. In fact, every health care professional is responsible for his or her own acts. The only time a surgeon is liable for another's act is when the surgeon specifically and precisely orders an action from a subordinate employee rather than to permit another professional to use expert judgement.
- **Negligent supervision** suggests a surgeon may be liable for something he or she should have done. This idea has never been used to win a liability case involving a CRNA in the state of Massachusetts.

[1] https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260
[2] 244 Code of Massachusetts Regulations (CMR) 4.07
[3] Certified Nurse Midwives and Maternity Care in Massachusetts Chartpack, HPC January 2022
[4] *AANA Journal* December 2016 Vol. 84, No. 6

A Federal CMS Requirement for CRNA Supervision is vastly misunderstood.

For the purposes of participating in the Medicare and Medicaid programs, hospitals must meet the Centers for Medicare and Medicaid Services (CMS) Part A Conditions of Participation (CoPs) requirement that a "CRNA is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed."[5] State Governors can opt-out of this CoP, [6] and Massachusetts is eligible to opt-out of this CoP.

CMS's federal regulation requiring supervision for Medicare Part A **does not** prohibit CRNAs from practicing independently. CRNAs can and do work independently every day in the Commonwealth.

In this CoP, "Supervision" is not defined other than the Operating Practitioner (surgeon, endoscopist, etc.) or physician anesthesiologist, who is immediately available, may supervise the CRNA. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by a physician anesthesiologist who is immediately available if needed, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a condition of participation. Physician anesthesiologists erroneously suggest that supervision is some type of quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision condition of participation. When this ideology is established, physician anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard.[7] However, the role of "supervisor" in this CoP is misunderstood (or misrepresented) to mean that the "supervisor" must direct the administration of anesthesia by the CRNA or is somehow liable for the actions of the CRNA. But nothing could be further than the truth. In fact, Massachusetts regulations clearly state that all APRNs (including CRNAs) are responsible for their own actions and require that APRNs carry liability insurance at a certain value.[8]

Billing and reimbursement for Anesthesia services is extremely complicated.

Anesthesia providers (physician anesthesiologists and CRNAs alike) rarely bill for their own services. Most anesthesia providers are employed either by a facility or by an out-sourced private practice company. In those instances, anesthesia providers release their billing rights to the employer and the billing for services is completed by an entire department or yet another outsourced billing service provider. The employer negotiates reimbursement with commercial/private insurance payers and those contracts are proprietary information. Medicare and Medicaid (MassHealth) determine their reimbursement rates for anesthesia services. Reimbursement for anesthesia services doesn't go directly to the providers; it goes to the employer. Anesthesia providers are then paid via payroll of the company.

- According to a nationwide survey of anesthesiology group subsidies,[9] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

- ***Private and Commercial payors in Massachusetts refuse to reimburse for CRNA services and/or reimburse at lower rates (Medicare and Medicaid reimburse in MA)*** Policies of unequal payment rates lead to higher cost healthcare delivery, without improving quality. Inconsistent insurance rates can pass the responsibility to patients to make up the difference in reduced payments known as "surprise billing "which increases costs and reduces access for patients. For instance, Cigna issued a new anesthesia policy that reduces payment for "QZ" (billing code for CRNA services) to 85% of the physician fee schedule. This discriminatory policy, which took effect on March 12, 2023, affects plans nationwide and puts patient access to care at risk and creates additional barriers to CRNA care. Importantly, this policy violates the federal provider nondiscrimination law.[10] Cigna has not provided any rationale for this cut in reimbursement specific to CRNAs. CRNAs provide the same high-quality, safe, and cost-effective care as anesthesiologists and should be reimbursed the same for providing identical services. Some specialties, as is the case with anesthesia, provide overlapping services. Both CRNAs and

[5] CFR § 482.52 Condition of participation: Anesthesia services. (a)(4)
[6] 482.52 Condition of participation: Anesthesia services. (c) (1-2)
[7] 63 FR 58813, November 2, 1998.
[8] 244 CMR 4.06, 4.09
[9] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.
[10] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers. --A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

physician anesthesiologists provide the same services. Reimbursing one provider less than another for the same service is discriminatory and only encourages higher cost delivery without improving quality. Other commercial/private payers in Massachusetts do not reimburse for CRNA services unless they are "supervised" by physician anesthesiologists even though there are no laws or regulations requiring it. These policies force anesthesia practices into expensive, inefficient practice models because they are unable to utilize physician anesthesiologists to personally administer anesthesia but pay their salaries that are usually double the salaries of CRNAs. Some state legislatures are considering legislation to prevent discriminatory reimbursement policies. Massachusetts legislators should consider the same in the pursuit of decreasing healthcare costs in the Commonwealth, allowing anesthesia practices to develop the most safe and cost-effective staffing models.

- ***Collaborative/consultative practice model is best for MA hospitals*** CRNAs are the most versatile and cost-effective anesthesia providers. Looking at the costs of various anesthesia staffing models in 12 anesthetizing locations, 12 CRNAs working autonomously or collaborating with surgeons costs $2.42 million while 12 CRNAs working autonomously and consulting with one anesthesiologist costs $2.83 million. These costs are significantly less than it would be to employ 12 anesthesiologists at $4.92 million or the $4.06 million needed to employ 12 CRNAs and 4 anesthesiologists to be working in medical direction practice models.[11]

- It is very important to note that ***this is not an initiative to eliminate physician anesthesiologists from patient care***. Instead, we are advocating for more consultative practice models, whereby CRNAs and physician anesthesiologists alike administer their own anesthetics, practice to the full extent of education, licensure, and comfort level. Complex cases and critically ill patients may benefit from the availability of two anesthesia providers (any combination of CRNAs and/or Physician Anesthesiologists) who can consult with one another to deliver necessary care. This flexible practice model allows safe and cost-effective care by efficiently deploying all anesthesia providers in the most appropriate manner and by maximization of ALL providers' skills, rather than in prescribed fixed anesthesia provider ratios that do not take into account surgical complexity and patient medical status. ***Please find more information on Efficiency Driven Anesthesia Modeling (EDAM) at anesthesiafacts.com.***

Thank you once again for the opportunity to share this important information. Please feel free to contact me directly for questions and/or further information.

Best Regards,

Melissa Croad

Melissa Croad, MSNA, APRN, CRNA

[11] Staffing costs are based on salary only. The equivalent median for the 2022 national salary estimates are from Salary.com for both CRNAs ($201,352) and MDAs ($410,300).

AANA Statement on the Most Cost-Effective and Safe Anesthesia Practice Models

Position Statement

In the United States, anesthesia services are commonly provided through one of three anesthesia provider models: by a Certified Registered Nurse Anesthetist (CRNA), by an anesthesiologist, or by both providers working together. Patient need, patient safety, access to care, and cost-efficiency to the healthcare system are all factors to consider in choosing an anesthesia provider model. The purpose of this statement is to highlight the most cost-effective anesthesia practice models and to recommend that these models are used in practice.

Research demonstrates all three models are equally safe.[1] Access to care is advanced by the availability of CRNAs. CRNAs are more evenly distributed across the population than are other providers, and predominate in rural America and in communities with higher populations of Medicare beneficiaries.[2,3]

The "CRNA" model and the "consultative" models demonstrate comparably high degrees of patient safety, quality and cost effectiveness.[4] Nurse anesthetists also practice in anesthesiologist medical direction anesthesia practice models. While we acknowledge that many CRNAs work in anesthesiologist medical direction anesthesia practice models, these models are not cost effective. Further, there is no evidence that anesthesiologist medical direction is any safer than the CRNA model or the consultative model.[4]

- **The CRNA model** is defined as an anesthesia practice model staffed and directed by CRNAs. The model has been shown to tolerate fluctuations in procedural volumes better than any of the other models in the market.[5] As interests compete for limited resources in healthcare, groups and facilities seeking to minimize cost of anesthesia services can achieve excellent cost savings as compared to other anesthesia practice models by implementation of an all CRNA model. The model avoids duplication of services, promotes efficient utilization of anesthesia providers and reduces cost.

- **The consultative model** is defined as an anesthesia practice model staffed primarily by CRNAs, with anesthesiologists serving as consultants. Like the CRNA model, the consultative model has been shown to tolerate financial fluctuations in procedural volumes as long as the number of anesthesiologists utilized maximizes efficiency. This model limits duplication of services, improves efficiency and reduces cost compared with "anesthesiologist medical direction" also known as the "anesthesia care team" practice models.[6]

- **The anesthesiologist medical direction model** is a payment model that drives anesthesia practice, in which an anesthesiologist claims 50 percent of an anesthesia fee for up to four concurrent anesthesia cases performed by CRNAs who each claim the remaining 50 percent. The model provides a powerful economic incentive for anesthesiologists to "medically direct" rather than provide anesthesia care. Medicare medical direction payment rules[7] require an anesthesiologist to perform seven specific tasks for each medical direction claim; the literature[8] and AANA member survey data find such tasks are often performed by the CRNA and not the anesthesiologist.

American Association of Nurse Anesthesiology | 222 South Prospect Ave | Park Ridge, Illinois 60068-4001 |
AANA.com Professional Practice Division l 847-655-8870 l practice@aana.com

References

1. Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Aff.* Aug 2010;29(8):1469-1475.
2. U.S. Government Accountability Office. Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. 2007; http://www.gao.gov/products/GAO-07-463. Accessed June 30, 2016.
3. Liao CJ, Quraishi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact On the Uninsured and Vulnerable Populations. *Nurs Econ.* Sep-Oct 2015;33(5):263-270.
4. Negrusa B, Hogan PF, Warner JT, Schroeder CH, Pang B. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. *Med Care.* May 20 2016.
5. Hogan P. et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nurs Econ*. 2010; 28:159-169.
6. See Patient-Centered Care: CRNAs and the Interprofessional Team. http://www.aana.com/resources2/professionalpractice/Pages/CRNAs-and-the-Interprofessional-Team.aspx.
7. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners. Sec. 50, Payment for Anesthesiology Services. Rev. 3476, March 11, 2016. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf. Accessed June 30, 2016.
8. Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics. *Anesthesiology.* Mar 2012;116(3):683-691.

Adopted by AANA Board of Directors July 2016.

American Association of Nurse Anesthesiology | 222 South Prospect Ave | Park Ridge, Illinois 60068-4001 | AANA.com
Professional Practice Division I 847-655-8870 I practice@aana.com

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
222 South Prospect Avenue
Park Ridge, Illinois 60068-4001
847.692.7050
AANA.com

Safe and effective anesthesia
CARE
for every patient.

Anesthesia Subsidies – Restraining Hospitals' Economic Viability

Anesthesia subsidies are a result of anesthesia revenues not being sufficient to cover anesthesia expenses thus forcing hospitals to support their anesthesia departments to assure high-quality anesthesia coverage. Anesthesia expenses include the cost of labor for the anesthesia providers and costs of supplies such as anesthetics used during a procedure. The trend for anesthesia subsidies began in 2000 when declining anesthesia revenues were driven by reduction in Medicare payments, increase in outpatient surgeries, changing clinician supply issues (e.g., work hours, less stress, anesthesia provider shortage), and increasing demand for anesthesia services (e.g., more baby boomers moving into Medicare).[1] These factors fueled the need for hospitals to pay anesthesia subsidies to maintain services.

Due to the proprietary nature of hospital finance data, access to anesthesia subsidy data is scarce; but according to the most robust Anesthesia Subsidy Survey available, the 2012 study illustrated that the average subsidy per anesthetizing location was $160,096 and in some regions, like the southern United States, the average was $180,992.[2] An anesthetizing location is defined as any area of a facility that has been designated to be used for the administration of anesthetic agents in the course of examination or treatment of a patient (e.g. operating rooms (OR) or procedures rooms.[3] This means that one hospital with 10 ORs may need to pay $1.69 – $1.89 million in an anesthesia subsidy.[2] The survey noted that Certified Registered Nurse Anesthetists (CRNAs) were either employed by an anesthesia group practice or were directly employed by the hospital. CRNAs that were directly employed by the hospital and had contracted anesthesiologists paid much higher subsidies for those anesthesiologists ($320,755 per anesthetizing location) compared to CRNAs employed by the anesthesia group practice ($154,552).[2] According to an MGMA 2013 cost survey, most hospitals continue to subsidize their anesthesia services, often exceeding $2 million annually, making anesthesia a loss leader on most hospitals' profit and loss statements.[4] To meet today's anesthesia demands, these subsidies are likely growing larger and placing greater burden on a hospital's narrow margin.

It has been shown that CRNAs provide safe and high-quality anesthesia services.[5,6] Further, anesthesia care delivery models centered on anesthesiologist medical direction or supervision billing practices are more costly and more likely to require a hospital anesthesia subsidy. On the other hand, CRNAs practicing to the full extent of their education and training while providing autonomous anesthesia services are least likely to require a subsidy to remain economically viable.[7,8,9] As Uwe E. Reinhardt, a renowned health economist from Princeton University once noted, physicians are fighting a losing battle against APRNs because, "They [APRNs] have economics and common sense on their side."[10]

References

1) Koch M, Calder DB. Four decisions that can affect your anesthesia subsidy. *Healthc Financ Manage*; 2011 Apr;65(4):104-8.
2) Healthcare Performance Strategies. Anesthesia Subsidy Survey. 2012.
3) Centers for Medicare and Medicaid (CMS). Relative Humidity: Waiver of Life Safety Code Anesthetizing Location Requirements; Discussion of Ambulatory Surgical Center Operating Room Requirements. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-25.pdf. Accessed 21 February 2020.
4) Morgan H. How hospital leaders can bend the anesthesia cost curve. *Healthc Financ Manage*; 2014 Nov;68(11):110-2, 114.
5) Dulisse B, Cromwell J (2010). No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians, *Health Affairs*, 29:1469 1475.
6) Negrusa B, Hogan PF, Warner JT, Schroeder CH, Pang B (2016). Scope of Practice Laws and Anesthesia Complications. No Measurable Impact of Certified Registered Nurse Anesthetists Expanded Scope of Practice on Anesthesia-related Complications. *Medical Care*, 54(10): 913-920.
7) Cintina I, Hogan P, Schroeder C; Simonson B; Quraishi J. Cost Effectiveness of Anesthesia Providers and Implications of Scope of Practice in a Medicare Population. *Nurs Econ.* 2018.
8) Hogan P, Siefert R, Moore C, Simonson B. Cost Effectiveness Analysis of Anesthesia Providers. *Nurs Econ*. 2010; 28:159-169..
9) North American Partners in Anesthesia. White Paper: Changing Anesthesia Providers – The Playbook for a Simple and Sustainable Transition. Available at: https://napaanesthesia.com/white-paper-changing-anesthesia-providers/ Accessed 21 Feb. 2020].
10) New York Times. Doctoring, Without the Doctor. Available at: https://www.nytimes.com/2015/05/26/health/rural-nebraska-offers-stark-view-of-nursing-autonomy-debate.html. Accessed 21 Feb. 2020.

Insurance Company Reimbursement Policies for Anesthesia Shifts Costs to Hospital Subsidies

beckersasc.com/anesthesia/insurance-company-reimbursement-policies-for-anesthesia-shifts-costs-to-hospital-subsidies.html

Anesthesia

Chris Hulin, DNP, MBA, CRNA, FAANA President Middle Tennessee School of Anesthesia - Thursday, February 16th, 2023

It is no secret that almost every hospital in the United States pays an anesthesia subsidy and that these subsidies are now starting to show up in outpatient centers. This rapidly growing disruption in the anesthesia market encourages healthcare systems to explore more efficient and effective models to mitigate expenses.

In a recent announcement, Cigna Healthcare informed anesthesia providers of their intent to reduce Certified Registered Nurse Anesthetists (CRNAs) reimbursement to 85 percent of the Physician Fee Schedule when providing services outside the restrictive Medical Direction billing model. Cigna reimbursement will only be at the 100% level if the most inefficient model of anesthesia staffing for hospital and health systems is utilized, which is the traditional 1:4 Medical Direction model.[1]

This reduction in reimbursement penalizes hospitals that choose to implement more efficient staffing models by shifting the anesthesia costs onto hospitals in the form of subsidies. The Medical Direction model also brings compliance risk as the physician anesthesiologist must comply with the Tax Equity and Fiscal Responsibility Act (TEFRA) requirements for billing which are almost statistically impossible to achieve.[3]

In contrast, when evaluating anesthesia services using Efficiency-driven Anesthesia Modeling, administrators are encouraged to consider anesthesia staffing models that are not based simply on the billing model of Medical Direction, which limits physician and CRNA ratios up to 1:4, without any demonstrated increase in quality or patient access.[2] A decision-making framework based on the science of public policy, the Efficiency-driven Anesthesia Modeling identifies the most appropriate anesthesia care delivery system for a location. This makes the most of a facility's resources by positioning efficient anesthesia provider staffing as a central objective.

Hospitals across the country are beginning to realize there are other models that offer the same level of quality, improved staffing, improved patient access to anesthesia care, and decreased overall costs and subsidies, with less risk of Medicare fraud.[4] One of these models

is the Collaboration/Team model, where physician anesthesiologists and CRNAs work collaboratively in ratios supported by the local patient population and acuity. The other model is a physician anesthesiologist or CRNA operating independently.

The announced payment cut to CRNAs working outside the narrow Medical Direction billing model directly shifts the payment reduction amount to any facility that will have to pay a subsidy and risks adding a subsidy to previously subsidy-free healthcare facilities. Essentially, Cigna's payment cut is penalizing facilities that seek a more efficient anesthesia model or facilities that simply cannot afford physician anesthesiologists in strict ratios of 1:4, or afford them at all, as we see in much of the rural United States and many outpatient facilities.[5] Health systems, providers, and patients all lose with this proposed payment cut; the only one who benefits is Cigna, who reported more than $6.7 billion in profits for 2022, while many hospitals are being forced to make tough decisions around cutting services due to massive financial losses.

If this move goes unchecked, hospital subsidies will continue to rise, impacting the consumer. Such policies will only serve to benefit the insurance companies through profits. I encourage all of you to pay attention to insurance carriers reducing their CRNA reimbursement policy and to stand up against arbitrary payment cuts like this one, that shift costs by increasing hospital subsidies for anesthesia services.

1. Cintina I, Hogan P, Schroeder C, Simonson B, Quraishi J. Cost Effectiveness of Anesthesia Providers and Implications of Scope of Practice in a Medicare Population. Nursing Economic$. 2018;36(2):67-73.

2. Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. Health Aff (Millwood). 2010;29(8):1469-1475. doi:10.1377/hlthaff.2008.0966

3. Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics. Anesthesiology. 2012 Mar;116(3):683-91. doi: 10.1097/ALN.0b013e318246ec24. PMID: 22297567.

4. (https://www.aana.com/docs/default-source/aana-journal-web-documents-1/legal-briefs-0214-p10-12.pdf?sfvrsn=d23d55b1_4).

5. Martsolf GR, Baird M, Cohen CC, Koirala N. Relationship Between State Policy and Anesthesia Provider Supply in Rural Communities. Med Care. 2019;57(5):341-347. doi:10.1097/MLR.0000000000001106