Testimony for the Health Care Cost Growth Benchmark Hearing
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First organized in 1940, the Massachusetts Association of Nurse Anesthesiology is the professional association representing Certified Registered Nurse Anesthetists (CRNAs) in Massachusetts. Today, our association represents a membership of over 1200 CRNAs and critical care nurses enrolled in the Nurse Anesthesiology programs at Northeastern University and Boston College. CRNAs in the Commonwealth work in hospitals, surgical centers, and offices, administering quality anesthesia care and compassion to our patients.

Thank you for this opportunity to testify regarding the Health Policy Commission's (HPC) healthcare cost growth benchmark. The costs associated with the continued barriers to services offered by Certified Registered Nurse Anesthetists (CRNAs) and other advanced practice registered nurses have historically been absent from benchmark data. Given the critical financial and economic situation in healthcare across the Commonwealth, we present the following information as Massachusetts CRNAs aim to collaborate with state and facility decision-makers to help alleviate strained budgets and address concerns about perceived anesthesia provider shortages.

Inefficient and expensive anesthesia practice models are costing the Massachusetts healthcare system millions in wasteful spending

The Massachusetts legislature and Governor Maura Healey have removed unnecessary practice restrictions for Certified Registered Nurse Anesthetists (CRNAs), enabling facilities in the Commonwealth to update their anesthesia practice models that fully utilize the skills of all CRNAs and physician anesthesiologists. However, outdated practice models are still prevalent, largely due to cultural and political influences by physician associations. It is time to set politics aside and for facilities to take advantage of the opportunities provided by Massachusetts state leaders to eliminate unnecessary, costly practice barriers. We hope the benchmark will include analyzing the costs associated with the under-use of CRNAs and other APRNs.

CRNAs are recognized as independent practitioners in Massachusetts, like other Advanced Practice Registered Nurses (APRNs). There are no laws or regulations requiring physician supervision for CRNAs to practice. On January 1, 2021, Governor Baker signed the "Patients First Act" into law, which granted full practice authority to all APRNs in the Commonwealth. Additionally, on June 4, 2024, Governor Healey decided to opt out of the CRNA supervision requirement set by the Centers for Medicare and Medicaid Services (CMS) in the Conditions of Participation in Medicare Part A. This move made Massachusetts the 25th state in the United States to opt out of this requirement.

The HPC's January 2022 report on Certified Nurse Midwives (CNMs) found that facility culture, bylaws, and commercial payer policy are barriers to CNM practice.[1] These barriers are similar to practice barriers that

[1] Certified Nurse Midwives and Maternity Care in Massachusetts Chartpack, HPC January 2022

CRNAs face, perhaps in an even more pervasive and profound manner than those of our CNM colleagues. Unnecessary practice barriers are incredibly costly to the already strained healthcare system and exacerbate the staffing challenges of anesthesia practices in the Commonwealth.

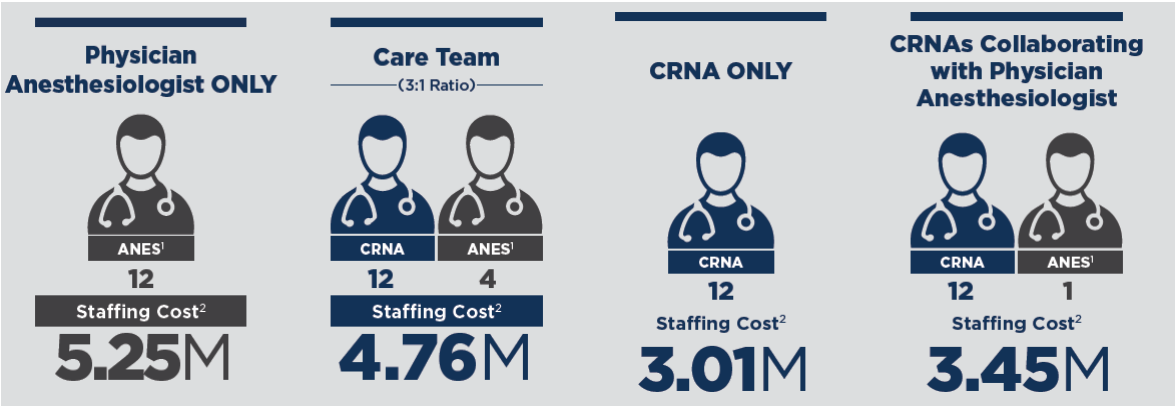
Anesthesia services subsidies

Anesthesia subsidies result from insufficient anesthesia revenues to cover anesthesia expenses, thus forcing hospitals to financially support their anesthesia departments to ensure high-quality anesthesia coverage. Anesthesia expenses include the cost of labor for the anesthesia providers and supplies such as anesthetics used during a procedure.[2]

According to a nationwide survey of anesthesiology group subsidies,[3] 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 hospitals responding to this national survey reported paying an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in an anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

Anesthesia groups who adopt an Anesthesia Care Team (ACT/Medical Direction) staffing model, either by choice or forced by political influences and reimbursement policies, will require a more significant subsidy to support the salaries of physician anesthesiologists who do not administer anesthesia but instead supervise CRNAs who don't need supervision. The ACT/Medical Direction staffing model is expensive and inefficient and does not maximize the value of *both* CRNAs and physician anesthesiologists. The ACT/Medical direction model is particularly susceptible to Medicare/Medicaid fraud, as literature and data from the American Association of Nurse Anesthesiology (AANA) member survey indicate that CRNAs frequently perform tasks credited to anesthesiologists.

Cost-effectiveness of anesthesia models



1 Physician anesthesiologist

2 Staffing costs are based on salary only. The median CRNA salary ($251,000) was taken from the 2024 AANA Compensation and Benefits Survey. The median physician anesthesiologist salary ($437,250) is based on information reported by HR professionals to Salary.com and accessed on December 2, 2024.

3 Epstein R, Dexter F. (2012). Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics. Anesthesiology, 116(3):683-691.

Updated Jan. 2025

[2] AANA Policy Statement Anesthesia Subsidies – Restraining Hospitals' Economic Viability

[3] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.

Hospital Bylaws, Cultural and Perceived Liability Barriers

Almost every facility in Massachusetts has adopted bylaws and departmental policies that are more restrictive than state laws and regulations. They require that CRNAs are unnecessarily supervised by physician anesthesiologists in the ACT/Medical Direction practice model, who provide little or no hands-on anesthesia care. Physician anesthesiologists use this as an opportunity to be reimbursed for "medical direction" under Medicare Part B. In this situation, 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.

An article published in 2020 by the Foundation of the American College of Healthcare Executives (ACHE)[4] outlined several factors influencing the adoption of anesthesia practice models. Instead of embracing models grounded in evidence-based research, institutions adhere to models influenced by other factors. The study indicates that these factors hinder the establishment of more efficient, cost-effective, and value-based practice models. Cultural norms within the medical community and established practices within local contexts contribute to organizational inertia, particularly in urban areas where the perception that CRNAs require supervision by physician anesthesiologists is prevalent. Surgeons' misconceptions regarding liability associated with CRNAs and facility administrators' lack of comprehension regarding CRNA practice further exacerbate these challenges. Additionally, physician anesthesiologists and other physicians and surgeons are more likely to wield significant influence over facility decisions, often without considering input from CRNAs.

Most 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. In these instances, two providers are paid for the services that can be done by one (increasing costs), and the opportunity for physician anesthesiologists to be available to personally administer anesthesia in additional operating rooms and other anesthetizing locations is lost (decreased access).

CMS 2023 state-level data[5] for Massachusetts reveals that physician anesthesiologists personally perform only 23.1% of anesthesia services for the Medicare population. This indicates that over 70% of anesthesia services are administered by CRNAs, while physician anesthesiologists primarily provide unnecessary supervision. While some emphasize that Medicare reimbursement remains the same regardless of the provider, it is crucial to recognize that the system funds salaries for both providers. This results in higher costs due to dual payment for a service that one provider could perform. Furthermore, the limited availability of physician anesthesiologists to personally administer anesthesia may reduce overall access to anesthesia care in other settings.

Anesthesia practices whose physician anesthesiologists don't fully utilize their skills by personally administering anesthesia but instead offer unnecessary "medical direction" for CRNAs lead to redundant services since CRNAs and physician anesthesiologists can provide equivalent services. This unnecessary supervision reduces access to care because the physician anesthesiologist, who could administer anesthesia directly, doesn't, thus reducing the pool of available anesthesia providers. Such practice models are inefficient and expensive. Given the current financial challenges facing healthcare systems in Massachusetts, sustaining these costly practice models, which involve paying more providers than required to deliver anesthesia, is irresponsible and wasteful.

Billing and reimbursement for Anesthesia services is complicated.

Anesthesia providers (physician anesthesiologists and CRNAs alike) rarely bill for their own services. Most anesthesia providers are employed either by a facility or private practice group. In those instances, anesthesia providers release their billing rights to the employer, and billing for services is completed by an entirely different department or an outsourced reimbursement specialty service provider. It is important to note that reimbursement for anesthesia services doesn't go directly to the providers; it goes to the employer, and anesthesia providers are then paid their salaries via the company's payroll based on the market value for services.

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[4] *Quality, Costs, and Policy: Factors Influencing Choice of Anesthesia Staffing Models*, ACHE Journal, Volume 65, Number 1, January/February 2020

[5] Area Resources Health File: https://data.hrsa.gov/topics/health-workforce/ahrf, CMS https://data.cms.gov/

Medicare and Medicaid reimburse 100% of the fee schedule for CRNA services. In contrast, commercial/private payers either do not reimburse or will reimburse at lower rates for the same services physician anesthesiologists provide. Legal precedent prevents reporting payments relating to health care.

Medicare and Medicaid determine their reimbursement rates for anesthesia services, while employers negotiate reimbursement rates with commercial/private insurance payers. Because these contracts are proprietary, it is difficult or impossible to determine reimbursement trends in these privately negotiated contracts. Complicating any potential attempt to study commercial/private reimbursement trends is *Gobeille v. Liberty Mutual Insurance Company,*[6] a 2016 legal case argued before the US Supreme Court. In this case, the US Supreme Court affirmed that the Employee Retirement Income Security Act (ERISA) pre-empts state law from requiring that certain self-insured payors be obliged to report payments relating to health care claims to state agencies for compilation in an all-inclusive health care database. This resulted in a significant decrease in commercial insurance data in the Massachusetts All Claims Data Base (ACDB) maintained by the Center for Health Information and Analysis (CHIA).

Some specialties, such as the case with anesthesia, provide overlapping services. Both CRNAs and physician anesthesiologists offer the same services. Policies of unequal payment rates lead to a higher cost of healthcare delivery without improving quality. CRNAs were granted direct reimbursement rights under Medicare, allowing them to bill directly for 100% of the physician fee schedule amount for services through the Omnibus Reconciliation Act of 1986.[7]

In the past, patients have been financially responsible for out-of-network or reduced reimbursement for CRNA services, leading to surprise medical bills without reductions in premiums paid to insurers. To eliminate surprise billing instances, the shortfall in reimbursement falls on the anesthesia provider group whose CRNAs provide full-service anesthesia care but are reimbursed at lower rates.

For instance, Cigna issued an anesthesia policy that reduces payment for CRNA services without "medical direction" to 85% of the physician fee schedule.[8] This discriminatory policy, which took effect on March 12, 2023, affects plans nationwide. Cigna has not provided any rationale for this cut in reimbursement specifically to CRNAs. In August 2024, Anthem Blue Cross Blue Shield announced that they, too, will be decreasing CRNA non-medical direction reimbursement to 85% of the physician fee schedule effective November 1 in several states.[9] In unconfirmed reports in Massachusetts, reimbursement for CRNA services is reduced by 30% across all insurers and 50% by one specific payer.

Notably, these policies violate the federal provider nondiscrimination clause in the Affordable Care Act.[10] Reimbursing one provider less than another for the same service is discriminatory and only encourages higher-cost delivery without improving quality. The policies also put patient access to care at risk, creating additional barriers to CRNA care.

Some commercial and private payers in Massachusetts mandate billing for CRNA services using a physician anesthesiologist's National Provider Identification Number (NPI) and refuse reimbursement for CRNA services unless they are "supervised" by a physician anesthesiologist. This practice attributes the service to a provider who did not directly administer anesthesia, effectively obscuring the involvement of the CRNA in reimbursement data trends. Furthermore, these policies compel anesthesia practices to adopt costly and inefficient practice models because they cannot deploy physician anesthesiologists to administer anesthesia directly yet still pay their salaries, typically double those of CRNAs.

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[6] https://www.scotusblog.com/case-files/cases/gobeille-v-liberty-mutual-insurance-company/

[7] Issue Briefs on Reimbursement and Nurse Anesthesia – 10th Edition, March 2022, AANA Division of Federal Governmental Affairs

[8] https://www.mercyoptions.net/wp-content/uploads/2022/12/Cigna-reimbursement-policy-updates-eff-03.12.2023.pdf

[9] https://providernews.anthem.com/new-york/articles/reimbursement-policy-update-professional-anesthesia-service-21004

[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)

Patients who receive care from CRNAs whose services are reimbursed at lower rates do not see decreased insurance premiums. The only benefactors of reduced reimbursement rates are the insurance carriers.

Some state legislatures are considering legislation to prevent discriminatory reimbursement policies. Massachusetts legislators and other stakeholders should consider the same in the pursuit of decreasing healthcare costs in the Commonwealth, allowing anesthesia practices to develop the safest and most cost-effective staffing models that maximize value. Insurance carrier reimbursement policies should be consistent with the scope of practice laws and regulations, and policies that impose practice restrictions or reduce reimbursement for CRNAs who provide the same full-service anesthesia care as their physician anesthesiologist colleagues should be prohibited.

Liability

"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.

- **Captain of the ship** was a basis for finding the surgeon responsible for every person working in the operating room, without regard to whether the surgeon did or did not try to exert control or even knew what the other personnel were doing. That theory has fallen into disfavor as courts recognize that today's operating rooms are more complicated facilities with more specialized personnel, some of whom are skilled in areas where the surgeon has little training.
- **Vicarious liability:** "A surgeon may be held legally responsible for the actions of a nurse anesthetist if the surgeon takes steps to intervene in the provision of anesthesia.
- **Negligent supervision** suggests a surgeon may be liable for something they should have done." [11]
  This idea has never been used to win a liability case involving a CRNA in Massachusetts.

"The controlling factor in determining whether a surgeon is to be held accountable for a nurse anesthetist's actions is whether, based on the facts of the case, the surgeon actually exercised control or had the right to exercise control over the nurse anesthetist during the surgical procedure. If not, the surgeon is likely not to be held accountable for the actions of the nurse anesthetist or adverse patient outcomes resulting from the administration of anesthesia. Under this control or right to control test, the scope of practice of the nurse anesthetist under state law is less important. Whatever state law provides, if a hospital requires some level of physician oversight of anesthesia services or if the surgeon intervenes in the administration of anesthesia, the surgeon may be liable for a nurse anesthetist's actions. As described previously, facility bylaws that are more restrictive or require supervision not required by state laws can increase surgeon and facility liability if unnecessary facility bylaws/policy is not followed even when no negligence has been determined. In the case of Denton Regional Medical Center v. LaCroix, the court found "Holding that medical-negligence claims against health-care providers are independent of direct-liability claims against the hospital and that hospital can be held liable even if the individual doctor is found not to be medically negligent."[12]

Most importantly, there is no initiative by Massachusetts CRNAs to eliminate physician anesthesiologists from patient care.

Instead, we advocate for the Consultative Practice Model (CPM), whereby both CRNAs and physician anesthesiologists administer anesthesia directly and 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 Physician Anesthesiologists) who can consult with one another to deliver necessary

[11] ASA Newsletter December 2000 Volume 64 Number 12

[12] https://casetext.com/case/denton-regl-med-v-lacroix

care. This flexible practice model allows safe and cost-effective care by efficiently deploying all anesthesia providers most appropriately and maximizing ALL providers' skills, rather than in prescribed fixed anesthesia provider ratios that do not consider surgical complexity and patient medical status.

In closing, we urge the HPC to recognize the significant financial impact of outdated anesthesia practice models and the underutilization of CRNAs in Massachusetts. The evidence highlights the inefficiencies, unnecessary costs, and restrictive policies contributing to wasteful healthcare spending. By including anesthesia service costs in benchmark data and supporting practice models that fully leverage the expertise of CRNAs, the Commonwealth can improve access to care, enhance patient safety, and alleviate financial strain on hospitals. We appreciate your time and consideration of these critical issues and look forward to collaborating on solutions that promote high-quality, cost-effective anesthesia care.

Please find more information on Efficiency Driven Anesthesia Modeling (EDAM) at anesthesiafacts.com.