AANA
American Association of
NURSE ANESTHESIOLOGY

December 12, 2022

Martin J. Walsh
Secretary
Department of Labor
Room S–3502
200 Constitution Avenue, NW
Washington, DC 20210

RE: RIN 1235–AA43 – Notice of Proposed Rulemaking: Employee or Independent Contractor Classification Under the Fair Labor Standards Act (87 Fed.Reg. 62218, October 13, 2022)

Dear Secretary Walsh:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this Notice of Proposed Rulemaking: Employee or Independent Contractor Classification Under the Fair Labor Standards Act (87 Fed.Reg. 62218, October 13, 2022). The AANA makes the following comments and requests:

- CRNAs Are Advance Practice Registered Nurses Who Have Highly Specialized Skills and are not Dependent on Training from Their Employer to Perform Their Work
- Place Greater Weight on the Factor of "Skill and Initiative" as Part of the DOL's Economic Reality Test

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than

59,000 CRNAs and SRNAs, representing about 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services. CRNAs also play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery and recovery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other

anesthesia providers or by anesthesia delivery model.[1] An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[2] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.[3] Most recently, a study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[4]

The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.[5] The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[6]

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[1] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[2] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475. http://content.healthaffairs.org/content/29/8/1469.full.pdf

[3] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[4] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[5] Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

[6] Liao, op cit.

AANA Comment: CRNAs Are Advance Practice Registered Nurses Who Have Highly Specialized Skills and are not Dependent on Training from Their Employer to Perform Their Work

CRNAs are advanced practice registered nurses (APRNs) and Medicare Part B providers who have highly specialized skills, and these specialized skills cannot be fulfilled by any worker. As APRNs, CRNAs practice with a high degree of autonomy and professional respect. CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care based on their education, licensure, and certification. They are the only anesthesia professionals with critical care experience prior to beginning formal anesthesia education. CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery and recovery. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Furthermore, these skills are not "dependent on training from the employer to perform the work." CRNAs have a minimum of 7 to 8 ½ calendar years of education and experience specific to nursing and anesthesia before they are licensed to practice anesthesia. The minimum education and experience required to become a CRNA include: a) a baccalaureate or graduate degree in nursing; b) an unencumbered license as a registered professional nurse and/or an advanced practice registered nurse (APRN) in the United States; c) a minimum of one year full-time working experience as a registered nurse in a critical care setting, of which the average experience of RNs entering nurse anesthesia education programs is 2.9 years; d) graduation with a minimum of a master's degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA); and e) passage of the National Certification Examination (NCE).

Nurse anesthesia programs range from 24-42 months; upon graduation, a student registered nurse anesthetist (SRNA) will have acquired, on average 8,636 hours of clinical experience. The COA

is the only agency recognized by the U.S. Department of Education (USDE) and Council for Higher Education Accreditation (CHEA) to accredit nurse anesthesia programs in the United States and Puerto Rico. There are currently 130 accredited nurse anesthesia programs. The accreditation standards for entry-level nurse anesthesia programs offering practice doctorate degrees and accreditation standards for postgraduate fellowships are written with input from a wide community of interest consisting of many individuals and groups, including CRNA practitioners and educators, nurse anesthesia students, administrators and faculty of colleges and universities, hospital administrators, state boards of nursing, the staff of the USDE, the CHEA and other nationally recognized accreditation agencies, members of the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA), and the Board of Directors of the AANA. The standards provide graduates with entry-into-practice competencies required at the time of graduation to provide safe, competent, and ethical anesthesia and anesthesia-related care to patients for diagnostic, therapeutic, and surgical procedures.

The NBCRNA develops and implements credentialing programs that support lifelong learning among nurse anesthetists. NBCRNA credentialing provides assurances to the public that certified individuals have met objective, predetermined qualifications for providing nurse anesthesia services. The NCE is for the SRNA who has successfully completed an accredited nurse anesthesia educational program and has been granted eligibility status to take the exam. The exam is a variable-length computerized adaptive test and is for entry into nurse anesthesia practice. Each candidate will take a minimum of 100 test questions — 70 questions representing the NCE content outline and 30 random, nongraded pretest questions. The maximum number of questions is 170 questions, which includes the 30 random, non-graded pretest questions. A maximum of three hours is allowed for the test period. CRNAs must be recertified every four years so they are current on anesthesia techniques and technologies. CRNAs must also pass a Continued Professional Certification (CPC) exam every eight years.

AANA Request: Place Greater Weight on the Factor of "Skill and Initiative" as Part of the DOL's Economic Reality Test

The AANA appreciates that the Department of Labor (DOL) is seeking to protect workers from misclassification while at the same time providing a consistent approach to those businesses that engage independent contractors. We also appreciate that DOL is concerned about misclassified workers being denied workplace protections and rights. However, we are concerned that the six-factor test could be applied too stringently and may wrongly preclude CRNAs from choosing to work as independent contractors. CRNAs may work as independent contractors in multiple arrangements including working with locum agencies and, in many instances, may work in various facilities at once. Furthermore, we believe it is important for the DOL to take into account the current anesthesia workforce shortage and the need for flexibility in the healthcare system to meet the demand for anesthesia services. According to a 2021 study by Negrusa, a baseline trend using data from 2017 show that there is an estimated 10.7% excess demand for anesthesia services, meaning that the labor market for anesthesia providers is short by over 9,000 providers.[7] According to this same analysis, shortfalls are to continue to 2027, though at a slower rate of decline. We also hold that CRNAs, who are APRNs, and who are engaging in independent contractor arrangements should be given special consideration and not be equated with gig workers. California recognized that CRNAs are different from typical gig workers and that is why the state later passed AB-2257, which amended AB-5 Worker Status: Employees and Independent Contractors, so that CRNAs were exempted as long as they "are solely performing the services under the contract under the name of the business service provider and the business service provider regularly contracts with other businesses." Given the benefit of hindsight in the case of California, we request that DOL take this into account during their rulemaking process. For these reasons, we believe greater consideration and weight should be given to the "skill and initiative" factor economic reality test. We believe weighing this factor more heavily over the other factors will strongly help the DOL in properly classifying workers. We stand ready to work with the DOL as these proposed rules are finalized and implemented.

[7] Negrusa et al 2021., Anesthesia Services: A Workforce Model and Projections of Demand and Supply. Nursing Economic$, 39(6), 275–284.

We thank you for the opportunity to comment on this notice of proposed rulemaking. Should you have any questions regarding these matters, please feel free to contact AANA Senior Associate Director, Federal Regulatory and Payment Policy, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,

Angela R. Mund, DNP, CRNA
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Lorraine Jordan, PhD, CRNA, CAE, FAAN, AANA Chief Advocacy Officer and AANA Foundation CEO
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