AANA
American Association of
NURSE ANESTHESIOLOGY

June 3, 2025

Dr. Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically via https://www.cms.gov/medicare-regulatory-relief-rfi

Dear Administrator Oz:

On behalf of the more than 65,000 members of the American Association of Nurse Anesthesiology (AANA), I submit these comments in response to your notice titled "Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information." AANA is the professional association representing certified registered nurse anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs) nationwide. CRNAs are advanced practice registered nurses (APRNs) who are autonomous anesthesia providers with extensive education and clinical training. AANA welcomes the opportunity to provide feedback on burdensome regulations and policies in the Medicare program and across the Centers for Medicare and Medicaid Services (CMS) that impact CRNAs and the patients and facilities they serve.

In these comments we recommend the following:

1. Remove Medicare's physician supervision requirements for CRNAs.
2. Allow CRNAs to serve as directors of anesthesia services.
3. Amend Medicare teaching rules so that physician anesthesiologists are compensated for training student registered nurse anesthetists on par with that of physician residents.
4. Include CRNAs as providers who can order and refer.

1. Remove Medicare's physician supervision requirements for CRNAs.

One of the most burdensome and unnecessary regulatory requirements in the Medicare program are the physician supervision requirements for CRNAs as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital Conditions of Participation (CoPs), and the Ambulatory Surgical Center Conditions for Coverage (CfCs). These requirements are not evidence-based, do not increase

patient safety, nor improve the quality of care. They are regulatory overreach contributing to waste and increased costs for facilities and inefficiencies in the Medicare program.

There is overwhelming evidence that CRNAs are safe and effective autonomous anesthesia providers.

CRNAs are autonomous anesthesia providers through their training and preparation. They are doctorally prepared, must be board certified, and must participate in continuing education and recertification every 4 years in order to practice. CRNAs provide expert anesthesia and pain management care across diverse clinical settings and are trained and licensed to care for all patients, including those with complex medical conditions.

A peer-reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia-related complications for CRNA-only care, physician anesthesiologist-only care, and a team-based approach to care, and found there were no differences in complication rates based on delivery model.[1] This corroborates an earlier peer-reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs and found no difference in outcomes compared to states that maintained supervision requirements.[2] A comprehensive literature review on anesthesia staffing models completed by the Cochrane Library in 2014 further reinforced these findings and found that there could be no definitive statement made about the superiority of any one anesthesia delivery model with respect to safety or adverse outcomes.[3]

These supervision requirements are regulatory overreach and deeply burden state resources.

There is simply no evidence that these supervision requirements are necessary for safety and there is no federal statutory language requiring them. In fact, these requirements were originally rescinded in a final rule on January 18, 2001,[4] but that final rule was withdrawn and replaced with a bureaucratic opt-out process requiring states to individually remove the supervision requirements.[5]

States are the proper authority on practice laws and these requirements are federal overreach. Yet for decades states have had the burden of navigating this onerous wasteful opt out process which is above and beyond what would be required in a state. A total of 25 states and one U.S. territory have

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[1] 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, available at http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[2] Dulisse B., et al., *No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians*, Health Affairs, August 2010, available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2008.0966.

[3] Lewis SR, et al., *Physician anesthetists versus non-physician providers of anesthesia for surgical patients*, Cochrane Database of Systematic Reviews, July 2014, available at: https://pubmed.ncbi.nlm.nih.gov/25019298/.

[4] *Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services*, 66 Fed Reg. 4674, January 18, 2001, available at: https://www.govinfo.gov/content/pkg/FR-2001-01-18/pdf/01-1388.pdf

[5] *Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services,* 66 Fed Reg. 56762, November 13, 2001, available at: https://www.govinfo.gov/content/pkg/FR-2001-11-13/pdf/01-28439.pdf

opted out of the federal supervision requirement. CMS' supervision requirements are more stringent than most state laws as 44 states do not have supervision in their Nurse Practice Act and Board of Nursing rules. Some states are actively pursuing an opt out from their Governor, spending resources on lobbyists and public relations firms. Other states are taking a break after years of no success due to politically driven opposition from physician groups. The physician opposition typically involves scare tactics with legislators, claiming that removing supervision would lead to patient deaths and would generally create unsafe situations for patients, which is contrary to the facts backed up by data. A few states have never attempted to pursue an opt out, fearing retaliation at places of employment, or as was the case in Virginia, their efforts were retaliated against with a bill that would define "supervision" in a more restrictive way than is currently required. The most recent state to remove supervision from its laws was West Virginia, accomplishing the feat in the 2025 legislative session after several unsuccessful attempts.

Even in states that do not have supervision in laws, the federal supervision requirement can confuse facilities and state policy makers. Some facilities do not understand that, by moving to a less expensive CRNA-only model of care, costs could be saved and used on other services. Similarly, confusion exists among some facility administrators and surgeons as to who is liable for CRNA action under the federal supervision requirement, even though CRNAs are personally responsible for the care they provide.[6] Physician opposition uses the federal supervision requirement to confuse legislators as to how CRNAs may legally practice in a state. There is simply no legitimate reason to keep the burden of the federal supervision requirements when more resources could be directed to improving access to quality anesthesia care.

> *CMS' supervision requirements increase inefficiencies and the potential for fraud in the Medicare program.*

As CRNAs are autonomous providers, they can bill Medicare Part B directly for payment without any physician supervision requirement via the QZ modifier.[7] The supervision requirements under the CoPs and CfCs instead incentivize the use of the medical direction payment model in Part B. This payment model allows physician anesthesiologists to spuriously collect 50 percent of the fee per case for up to four concurrent cases performed by CRNAs. Under this model, the CRNAs bill for the services they are performing at 50 percent of the Medicare Physician Fee Schedule (PFS) amount, and the physician anesthesiologist will bill 50 percent per case as well, concurrently billing a combined 200 percent of the PFS, without even providing direct patient care for the entire service. This model of care creates unnecessary payments at the expense of American taxpayers. This is one of the most expensive models possible, but every iteration of the care team model is necessarily less efficient and more expensive than a model that allows for autonomous practice of CRNAs.

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[6] American Association of Nurse Anesthesiology, *Code of Ethics for the Certified Registered Nurse Anesthetists*, July 2018, available at: https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse_?fr=sZGY1YTU2NDAxMjU.

[7] *Payment for services of CRNAs*, 42 CFR §414.60, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-B/section-414.60.

A physician anesthesiologist must meet and document their involvement in all seven key steps of an anesthetic delivery as required by the medical direction regulations in order to be reimbursed for this service.[8] Failure to meet all seven steps disqualifies the anesthesiologist from billing for medical direction. This payment model is rife with fraud as evidence shows anesthesiologists consistently fail to meet these medical direction regulations, resulting in significant lapses as made evident by a 2012 study in Anesthesiology, the official journal of the American Society of Anesthesiologists.[9] The study found that at even a 1:2 anesthesiologist to CRNA ratio, lapses occurred on 35 percent of days. These requirements are not only wasteful but are not being followed in regular practice.

Rural and underserved areas are especially burdened by these requirements.

Supervision requirements drive up costs for healthcare facilities and rob them of the flexibility of choosing healthcare delivery in an efficient manner. Rural hospitals are often running negative margins and a factor contributing to this is administrative costs.[10] Compliance with needless federal supervision requirements only adds to their administrative burden as they must document physician involvement. Research shows that hospitals have higher revenue when CRNAs are able to practice without supervision.[11] CMS' own analysis in the 2001 final rules that should have removed these requirements found that there would be no additional costs to the government in implementing their removal.[12] Struggling hospitals and their patients have everything to gain with no negative impact on government spending.

Additionally, the country faces an anesthesia provider shortage that is expected to continue.[13] CRNAs already serve more rural communities as well as areas with higher concentrations of low-income, Medicaid-eligible, and uninsured patients.[14] In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma

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[8] *Conditions for payment: Medically directed anesthesia services*, 42 CFR § 415.110, available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-415/subpart-C/section-415.110.

[9] Epstein RH, et al., *Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics*, Anesthesiology, March 2012, available at: https://pubmed.ncbi.nlm.nih.gov/22297567/.

[10] Kaiser Family Foundation, *10 Things to Know About Rural Hospitals*, April 16, 2025, available at: https://www.kff.org/health-costs/issue-brief/10-things-to-know-about-rural-hospitals/.

[11] Cintina I., et al., *Cost Effectiveness of Anesthesia Providers and Implications of Scope of Practice in a Medicare Population*, Nursing Economic$, March-April 2018, available at: https://alabamacrna.org/Content/downloads/Nursing_Economics_2018.pdf.

[12] *Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services*, 66 Fed Reg. 4674, 4685, January 18, 2001, available at: https://www.govinfo.gov/content/pkg/FR-2001-01-18/pdf/01-1388.pdf; and *Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services,* 66 Fed Reg. 56762, 56768, November 13, 2001, available at: https://www.govinfo.gov/content/pkg/FR-2001-11-13/pdf/01-28439.pdf

[13] Negrusa et al., *Anesthesia Services: A Workforce Model and Projections of Demand and Supply*, Nursing Economic$, December 2021, available at: https://www.researchgate.net/publication/357569422_Anesthesia_Services_A_Workforce_Model_and_Projections_of_Demand_and_Supply.

[14] See Liao CJ, et al., *Geographical imbalance of anesthesia providers and its impact on the uninsured and vulnerable populations*, Nursing Economic$, September 2015, available at: https://pubmed.ncbi.nlm.nih.gov/26625579/ and Palmer A, et al., *An examination of factors contributing to different anesthesia models in underserved areas*, Nursing Outlook, March 2025, available at: https://pubmed.ncbi.nlm.nih.gov/39874636/.

stabilization, and pain management capabilities. Despite fully qualified CRNAs being available, these supervision requirements impede access and can delay care for the most impacted patients.

Changes required:

Rescind physician supervision requirements for CRNAs as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital Conditions of Participation (CoPs) and the Ambulatory Surgical Center Conditions for Coverage (CfCs):

- Amend 42 CFR § 482.52(a)(4), 485.639 (c)(2), 416.42 (b)(2), and 485.524 (d)(3)(ii)
- Eliminate 42 CFR § 482.52(c), 485.639 (e), 416.42 (c), 485.524 (d)(5)

2. Allow CRNAs to serve as directors of anesthesia services.

Currently, Medicare hospital CoPs only allow a physician to serve as director of anesthesia services. CRNAs are highly educated and credentialed anesthesia experts and are fully qualified to serve in this role. In many hospitals the CRNA may be the only healthcare professional possessing expertise and training in the anesthesia specialty. In fact, CRNAs are already authorized in some cases to direct anesthesia services in all branches of the U.S. military where they are the primary anesthesia providers in active duty and have full practice authority.[15] Yet this regulation leaves a wide door open to require unqualified individuals inexpert in anesthesia care to direct hospital anesthesia services solely because that provider is a doctor of medicine or of osteopathy. Additionally, the hospital may contract with and pay a stipend to a physician anesthesiologist for department administration only, solely because there is a federal regulation. This increases waste by creating the need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department rather than allowing the hospital the flexibility to retain those services if they decided that worked best for their facility.

The scope of nurse anesthesia practice includes responsibilities for administration and management, quality assessment, interdepartmental liaising, and clinical as well as administrative oversight of other departments. As CRNAs possess a strong foundation in nursing, critical care, anesthesia, and pain management, they are frequently called upon to assume administrative and executive positions. CRNAs are regularly selected to function as anesthesia and surgery department administrators, chief nurse executives, chief operating officers and chief executive officers of hospitals. Especially for rural hospitals that run on razor tight margins and disproportionately rely on CRNAs, facilities should be able to select the very best anesthesia leader for the job while maximizing flexibility and efficiency.

Changes required:

Amend 42 CFR § 482.52 to include CRNAs as eligible to direct anesthesia services.

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[15] Defense Health Agency, *Administrative Instruction: Utilization of Anesthesia Services in the Military Medical Treatment Facilities*, November 2023, available at: https://www.health.mil/Reference-Center/DHA-Publications/2023/11/08/DHA-AI-6025-07.

3. Amend Medicare teaching rules so that physician anesthesiologists are compensated for training student registered nurse anesthetists on par with that of physician residents.

Medicare teaching rules disadvantage the clinical training of student registered nurse anesthetists (SRNAs) by paying a physician anesthesiologist only 50 percent of the PFS amount for supervising an SRNA. Physician anesthesiologists receive 100 percent of the PFS for supervising up to two physician residents and CRNAs also receive 100 percent for supervising up to two SRNAs. By creating a payment disincentive for anesthesiologists to teach SRNAs, these rules erroneously imply that services provided by a teaching anesthesiologist and SRNA are less valuable. This is blatant discrimination, and these rules have persisted for years. This is despite Congress directing that the teaching rules for CRNAs be "consistent" with the rules for anesthesiologists[16] and CMS' admission that an anesthesiologist billing 100 percent of the PFS for each case involving an SRNA "would establish parity of payment."[17] We urge you to correct this error so current and future SRNAs have more fair treatment in their clinical training.

Change required:

Amend 42 CFR §414.46(d)(2)(i) and (d)(2)(ii) and/or (e) so anesthesiologists receive 100 percent of the PFS amount for supervising up to two cases with SRNAs.

4. Include CRNAs as providers who can order and refer.

CRNAs have been excluded as providers authorized to order and refer medically necessary services in Medicare. There is no federal statute or regulation prohibiting CRNAs from providing this care. Yet CRNAs are not included in CMS' list of ordering and referring providers[18], or ordering and referring data file[19], and a Medicare Learning Network article revised in October 2015 does not list CRNAs among the specialists that can order and refer.[20] As CRNAs are not included among the type or specialty to be on the CMS ordering and referring file, CRNAs who order and specialists they refer to are not being reimbursed. This denies the practitioner who provides the service their proper reimbursement and impedes state law which is the authority on practice laws. If the service is performed in a state that has authorized CRNAs to perform the service, CMS should not improperly

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[16] *Medicare Improvement for Patients and Providers Act of 2008*, P.L.110-275 Sec. 139, available at: https://www.govinfo.gov/content/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf.

[17] *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010*, 74 Fed. Reg. 61872, November 25, 2009, available at: https://www.govinfo.gov/content/pkg/FR-2009-11-25/pdf/E9-26502.pdf.

[18] *Who can order and certify?,* Updated September 10, 2024, available at: https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/ordering-certifying#eligible-specialty-types.

[19] *Ordering and Referring dataset*, Updated May 28, 2025, available at: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring.

[20] *Medicare Learning Network MLN Matters Article, SE1305 Revised, Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims* (Change Requests 6417, 6421, 6696, and 6856), Revised Jan. 26, 2015, available at: https://wayback.archive-it.org/2744/20150728222843/http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf.

be denying reimbursement. In fact, CMS confirmed in a 2012 rule Medicare coverage of all Medicare CRNA services within their state scope of practice.[21]

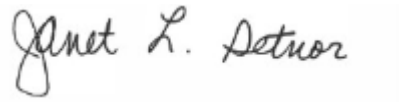
Patients are deeply impacted by denied orders and referrals because these denials can increase systemic delays in care. As more CRNAs work in rural areas these denials are especially impacting rural patients access to needed services such as laboratory services and physical therapy related to chronic pain management services. By adding CRNAs to all CMS ordering and referring materials, CMS can increase patient access, integrated care, and reduce waste caused by needlessly denied referrals.

Changes required:

Add CRNAs to CMS' list of ordering and referring providers, ordering and referring data file, and all related educational materials.

I thank you for your time and attention to this important issue and the critical role of CRNAs in our nation's healthcare workforce. AANA stands ready to assist you with reducing unnecessary regulatory burdens and making our health programs as effective as possible. Should you have any questions or need to request a meeting please contact Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com.

Sincerely,



Janet Setnor, MSN, CRNA, Col. (Ret), USAFR, NC
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrida Lusis, AANA Chief Advocacy Officer

[21] *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non- Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013*, 77 Fed. Reg. 68892, 69005 et seq., Nov. 16, 2012, available at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf. Rule amending 42 CFR §410.69(b), Certified Registered Nurse Anesthetists scope of benefit.