AANA
American Association of
NURSE ANESTHESIOLOGY

April 3, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244

Dear Administrator Oz:

On behalf of the 65,000 members of the American Association of Nurse Anesthesiology (AANA), I wish to congratulate you on your confirmation as Administrator of the Centers for Medicare & Medicaid Services (CMS). We stand ready to serve as a resource to you and CMS and are requesting a meeting with you to discuss our specific policy changes that could drive efficiencies and flexibilities within the U.S. healthcare system.

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 through their training and preparation. CRNAs 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. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

There is overwhelming evidence that anesthesia care provided independently by CRNAs is just as safe as the anesthesia care provided under physician supervision or by our physician anesthesiologist colleagues. Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most efficient model for anesthesia delivery.[1] The anesthesia care team model (with up to 1:4 physician anesthesiologist to CRNAs) is one of the most inefficient anesthesia delivery models possible. Allowing for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs. Removing existing barriers, which are detailed below, to allow these flexibilities aligns with the

[1] American Association of Nurse Anesthesiology, CRNAs are the Most Versatile and Cost-Effective Anesthesia Providers, Updated January 2025, available at: https://www.anesthesiafacts.com/wp-content/uploads/2025/01/CRNA-Cost-Effective-General-AANA.pdf

Administration's goal to reduce unnecessary regulations and make healthcare more efficient, both from a resource cost and quality of care perspective.

In October 2019, President Trump issued the *Executive Order on Protecting and Improving Medicare for Our Nation's Seniors*, which called for removing unnecessary supervision requirements that were more stringent than state requirements and limited healthcare professionals from practicing at the top of their licensures. We request your assistance in continuing this important work, which is now more critical than ever given existing anesthesia workforce shortages. These shortages are expected to increase in the future,[2] creating further urgency for the removal of these supervision requirements.

There exists clear evidence demonstrating the safety of CRNAs autonomously delivering anesthesia care. 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.[3] 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.[4] 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.[5]

Despite the extensive education, training, and continuing education requirements that CRNAs must complete and maintain, CMS currently places onerous and unnecessary physician supervision requirements on CRNAs as part of the Medicare hospital and critical access hospital Conditions of Participation (CoPs) and ambulatory surgical centers Conditions for Coverage (CfCs). These supervision requirements are in place at the behest of physician special interests, specifically physician anesthesiologists, that are more motivated by securing higher payment for themselves than reducing the burden on and cost to the healthcare system.

These requirements remain, despite the evidence overwhelmingly demonstrating that CRNA independent practice is safe and effective. While the Medicare regulation allows states to opt out of this requirement for CRNAs, the bureaucratic process to do so is onerous, and CRNAs are the only provider type required to go through this hurdle. To date, 25 states have opted out of the

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

[3] 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.

[4] B. Dulisse and J. Cromwell, No Harm Found When Nurse Anesthetists Work Without Physician Supervision, Health Affairs, 29: 1469-1475 (2010).

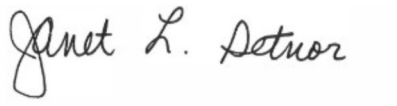
[5] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anesthetists versus non-physician providers of anesthesia for surgical patients, Cochrane Database of Systematic Reviews, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2, (2014).

CMS supervision requirement, while 43 states do not have any supervision requirements in their nursing/medicine laws or rules.

These requirements rob local healthcare facilities of the flexibility of choosing healthcare delivery in an efficient manner. CMS has the authority to make changes to these requirements, and we respectfully request that you permanently eliminate these supervision requirements along with the opt-out requirement. This would serve to reduce healthcare costs, increase flexibility for facilities and localities, and improve efficiencies at all levels of the U.S. healthcare system without compromising the quality of care being provided.

We would be honored to meet with you in the coming months to discuss CRNA practice and related policy changes that could drive efficiencies and flexibilities within the U.S. healthcare system. I look forward to this collaboration and to a fruitful working relationship over the next several years. For any questions or comments, and to schedule a meeting, please do not hesitate to reach out to Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com.

Sincerely,



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

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