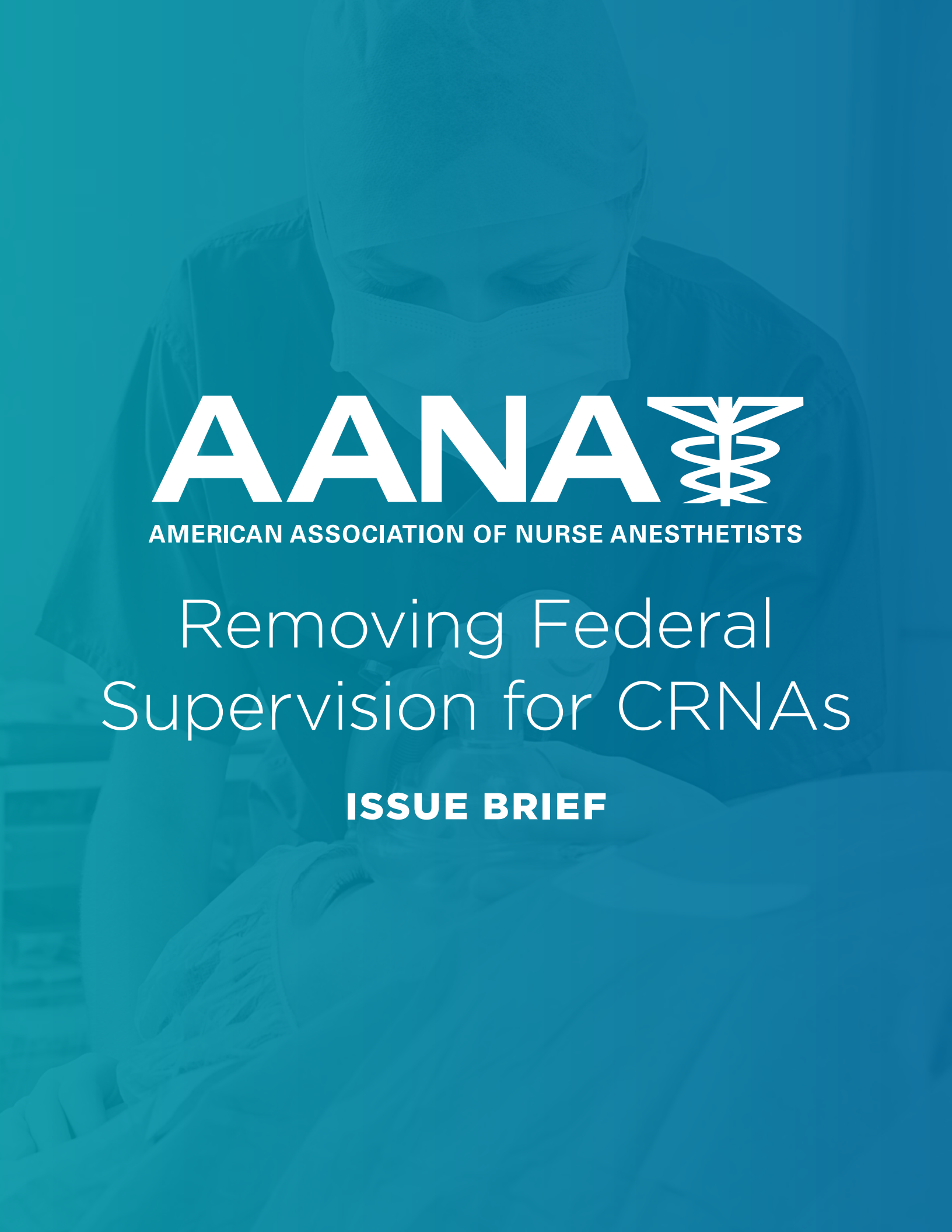

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AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Removing Federal Supervision for CRNAs

ISSUE BRIEF

"Eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession."

Executive Order 13890
***Protecting and Improving Medicare for Our Nation's Seniors*, Oct. 3, 2019**

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Background

Certified Registered Nurse Anesthetists (CRNAs) have been providing anesthesia in the United States for more than 150 years. CRNAs are anesthesia professionals who safely administer more than 49 million anesthetics to patients each year in the United States and are the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, pain management, and trauma stabilization services. CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

In January 2001, the Centers for Medicare & Medicaid Services (CMS) adopted a final rule which allowed reimbursement for services provided by CRNAs that were not conducted under the supervision of a physician. This rule would have allowed individual states to decide how anesthesia would be administered according to the needs of each state. In November 2001, CMS changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt out of this facility reimbursement requirement which applies to hospitals and ambulatory surgical centers. As states have continued to opt out of federal supervision requirements, removing barriers to practice, increasing access to care and decreasing healthcare costs, Executive Order 13890, *Protecting and Improving Medicare for Our Nation's Seniors,* was issued to help remove these unnecessary barriers. This order called for "proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws." **Removing the Medicare physician supervision condition of participation is an important step to reforming healthcare in America.**

STATES THAT HAVE PERMANENTLY OPTED OUT OF THE SUPERVISION REQUIREMENT

Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, Wisconsin, California, Colorado, Kentucky, Arizona

STATES THAT REMOVED STATE BARRIERS TO CRNA PRACTICE DURING THE PANDEMIC

Alabama, Connecticut, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, Tennessee, West Virginia, Wisconsin

CENTERS FOR MEDICARE AND MEDICAID SERVICES SAY CRNAS AMONG MOST UTILIZED

A recent CMS report on patient services noted that CRNAs are among the top 20 specialties that served the most beneficiaries between March 2020 and June 2020, during the beginning of the pandemic.

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Removal of Barriers to CRNA Practice During COVID-19

The COVID-19 pandemic led states to move to reduce barriers to critical care. During the pandemic many states temporarily removed state-level physician supervision and other barriers to CRNA practice by Executive Order, allowing CRNAs and other advance practice registered nurses (APRNs) to provide critical, life-saving care without unnecessary supervision. Arizona went further than most states, choosing to become the 18th state to fully opt out of the Medicare physician supervision requirement. **These state actions acknowledge the high level of skill and care that CRNAs provide while practicing independently to their full scope of practice.**

In March 2020, CMS temporarily removed physician supervision of CRNAs during the COVID-19 pandemic. Furthermore, the Department of Health & Human Services (HHS) issued guidance to state governors, urging them to remove supervision in the states and to free up providers to practice to their full scope. This move increases the capacity of the healthcare workforce at a time when that capacity is severely strained, particularly in rural areas. It is imperative that providers are practicing at the top of their licensure to deal with the crisis.

Removing barriers to CRNAs during the COVID-19 health emergency is critical because CRNAs are uniquely educated and positioned to bring much needed skills and treatment to COVID-19 patients. All CRNAs have at least one year of experience as an RN in a critical care setting, with the average CRNA having 3 years of this experience before becoming a CRNA. CRNA expertise in airway management, hemodynamic monitoring, management of patients on ventilators, placement of invasive lines, and overall management of critically ill patients uniquely positions them to provide life-saving care to those suffering from COVID-19, all without the need for physician supervision.

"These [scope-of-practice] restrictions are inefficient, increase costs, and reduce access to care. As leaders of public and private research who interact with and study the U.S. health workforce, we believe it's time to revise the country's antiquated patchwork of laws that restrict the health system's ability to innovate. We should improve our approach to regulating health professionals' scope of practice so that regulations better serve the needs of patients, rather than protect turf in the battles among health professions."

New England Journal of Medicine, Feb. 13, 2020

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Alignment with Independent Recommendations and Fact Based Policy

CMS' temporary removal of physician supervision requirements for CRNAs aligns with a number of assessments and recommendations that have called for implementing permanent full practice authority for CRNAs and other APRNs, and removing unnecessary supervision requirements:

SOURCE MATERIALS

The New England Journal of Medicine

The Administration's Executive Order 13890

The Bipartisan Policy Center's Rural Healthcare Task Force Report

More than Twenty Leading Think Tanks and Organizations

Institute of Medicine Report on The Future of Nursing

Multiple independent think tanks and health organizations have called for the removal of CRNA supervision and other unnecessary barriers to care. The pandemic and the temporary removal of these restrictions has showcased how unnecessary they are, and prove that they only serve to decrease access and increase costs. Allowing providers to practice to the full scope of their training and licensure will help increase access and competition, lower costs and maintain quality and safety in the Medicare program.

Several Executive Orders were issued during the pandemic in an effort to increase access to care during the public health emergency. The previous Administration released Executive Orders 13890 and 13924, which called for a review of regulatory changes that took place during the COVID-19 pandemic and an assessment of which should be permanent.

COST EFFECTIVENESS OF ANESTHESIA MODELS

When physician supervision restrictions limit CRNAs' practice, health care costs escalate.

AUTONOMOUS/CRNAS COLLABORATING WITH SURGEONS

$2M

12 CRNA Staffing Cost[1]

CRNAS COLLABORATING WITH ANESTHESIOLOGISTS

$2.4M

12 CRNA, 1 ANES[2] Staffing Cost

ANESTHESIA CARE TEAM (3:1 RATIO)

$3.68M

12 CRNA, 4 ANES Staffing Cost

PHYSICIAN ANESTHESIOLOGIST ONLY

$5.04M

12 ANES Staffing Cost

[1] Staffing costs are based on salary only. The median CRNA salary ($166,540) was taken from the 2018 AANA Compensation and Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th pctl salary ($420,284) according to HR Reported data as of March 29, 2018, Salary.com

[2] Physician anesthesiologist

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Expanding Access and Reducing Costs

Removing unnecessary supervision and allowing CRNAs to practice to the full extent of their education and skills will help the healthcare system deal with the ongoing effects of COVID-19 and be prepared for the resumption of elective procedures, in the most cost-effective and safe way possible. A study by the Lewin Group shows that a CRNA practicing without supervision is the most cost-effective method of anesthesia delivery. Additionally, a study comparing educational costs showed that CRNAs are most cost-effective to educate than other anesthesia professionals.

In addition to ensuring a smooth transition when elective procedures resume, CRNAs are critical to ensuring access to rural and underserved populations. Nurse anesthesia services are crucial to rural healthcare. As the sole anesthesia providers in the vast majority of rural hospitals, CRNAs enable these facilities to offer surgical, obstetrical, trauma stabilization, interventional diagnostic, and pain management services. A study published in Nursing Economics showed that CRNAs disproportionately serve these areas: "Compared to anesthesiologists, CRNAs are more likely to be found in counties where populations have lower median incomes but also where unemployment, the uninsured, and Medicaid are more densely populated. Certified registered nurse anesthetists provide anesthesia services to these vulnerable populations." Removing these barriers is a key part to ensure that vulnerable populations have access to care, an important step in helping to address health disparities.

ANESTHESIA PAYMENT MODEL	FTES / CASE	CLINICIAN COSTS PER YEAR / FTE
(a) CRNA Non-medically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist annual pay (mean)	$540,314	MGMA, 2014
CRNA annual pay (mean)	$170,000	AANA, 2014

Comparative costs of anesthesia care based on delivery models.

Providing the Highest Quality Care

In addition to being the most cost-effective delivery method for anesthesia, CRNAs practicing independently are also one of the safest models of anesthesia delivery. Multiple studies have compared the safety of anesthesia delivery for various models, including a CRNA practicing independently and supervised. These studies have consistently found that a CRNA practicing independently, without physician supervision, provides the same level of safety at a lower cost.

- A study published in **Medical Care** found no difference in safety outcomes based between different delivery models.
- A study published in **Health Services Research** showed no difference in outcomes between CRNA only and anesthesiologist only facilities in maternal care.
- A study published in **Health Affairs** found that there was no difference in anesthesia care safety between states that had removed supervision and allowed full practice, versus those that maintained supervision.
- A study published in **Journal of Healthcare Quality** showed that CRNAs providing fluoroscopic guided injections had similar complication rates to physicians engaged in the same procedure.

CRNAs have full practice authority in the Army, Navy, and Air Force and are the predominant providers of anesthesia on forward surgical teams and in combat support hospitals, where 90% of forward surgical teams are staffed by CRNAs. The move to suspend supervision requirements at the state and federal level is an acknowledgement of the skills and safety of CRNAs. **If CRNAs are able to deliver life-saving care in the middle of the worst pandemic in a century, there is no reason that they shouldn't be able to deliver this same care, practicing independently, after the pandemic has abated.**

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