



## Federal Requirement for Physician Supervision of CRNAs

### Introduction

Federal law states that for a hospital, a Critical Access Hospital (CAH) or Ambulatory Surgical Center (ASC), to participate in the Medicare program, that facility must comply with requirements such as having a physician supervise Certified Registered Nurse Anesthetists (CRNAs) unless a state chooses to opt-out of the supervision requirement (42 CFR §§ 482.52; 485.639; 416.42). To opt-out, a state's governor must ensure that the state meets three conditions before sending a letter to the Center for Medicare & Medicaid Services (CMS) requesting the opt-out:

1. The state's governor has consulted with the state's boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state; and
2. That it is in the best interests of the state's citizens to opt-out of the current federal physician supervision requirement; and
3. That the opt-out is consistent with state law

Currently 40 states do not require physician supervision of CRNAs via their nursing or medical statutes or licensing requirements. Letting states decide this issue without Federal involvement or interference is consistent with Medicare's policy for reimbursing CRNA services according to their state scope of practice (42 CFR 410.69(b), CMS-1590-FC).

### Data

Although many studies have demonstrated the high quality of CRNA care, a 2010 study published in *Health Affairs* led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated (Cromwell, D. B., 2010). The researchers examined Medicare records from 1999-2005, compared anesthesia outcomes in 14 states that had opted-out of the Medicare physician supervision requirement for CRNAs, with states that had not opted-out (to date 17 have opted-out). The researchers found that anesthesia has continued to grow more safe in opt-out and non-opt-out states alike. After reviewing the article the *New York Times* stated, "In the long run there could also be savings to the health care system." (Editorial *New York Times*, September 6, 2010). A Lewin Group study found that of the anesthesia delivery models: CRNAs working solo, anesthesiologists working solo, or CRNAs and anesthesiologists working together; the solo CRNA practice model is 25% more cost-effective than the next least expensive model (Hogan, P. F., et al, 2010).

## **Recommendation**

The National Rural Health Association believes that the removal of the physician supervision requirement of CRNAs by CMS would be consistent with the promotion of patient access to high quality, cost-effective healthcare. By adopting such a regulatory change, CMS would permit states and local healthcare facilities the opportunity to decide what the best anesthesia staffing model is for patient care and safety, and allow optimal use of the available anesthesia workforce. States would be free to decide this issue as they do all other types of health policy through their own statutes and regulations, rather than a precarious opt-out process that is subject to instability and reversal that puts rural healthcare access at unnecessary risk.

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