Federal Medicare Anesthesia Supervision State Op-Out
(Informational Discussion)

What the board will be discussing: Certified Registered Nurse Anesthetists (CRNAs) have officially asked the Nurse Physician Advisory Task Force for Colorado Healthcare (NPATCH) to take up and consider an opt-out of the Medicare requirement for physician supervision of certified registered nurse anesthetists (CRNAs). Because federal law gives Governor's the authority to opt states out of the federal Medicare requirement, a reasonable assumption is that the opt-out has already been presented to the Office of the Governor. CMS will be asked to testify at NPATCH on this matter. Because CMS has previously sued a Colorado Governor over a limited opt-out, and because of the passionate interest in this issue by CMS members, a discussion on current efforts by CRNAs to opt Colorado out of the supervision requirement is needed.

CMS policy: Scroll down to review

Most Recent Opt-Out Colorado History: In 2010, Governor Bill Ritter signed a letter to the Centers for Medicare and Medicaid Services opting Colorado out of the Medicare requirement for physician supervision of CRNAs in certain facilities. CMS asked the governor to delay his decision in order to bring all stakeholders to the table to try to achieve a mutually beneficial alternative, but he did not do so. As a result, CMS joined the Colorado Society of Anesthesiologists (CSA) in pursuing legal action to stop the opt-out. This action was taken because CMS believed that the opt-out was inconsistent with Colorado law and with the CMS goal to make Colorado the safest state in the country for patients (see CMS policy below).

Colorado Court Decisions Relating to the Ritter Opt-Out: The Colorado Supreme Court held that CMS Medicare regulations permit the Colorado Governor to opt-out of Medicare reimbursement requirements for physician supervision of CRNAs in critical access and selected rural hospitals. A Denver District Court judge held that Colorado law permits CRNAs to practice without physician supervision. The Colorado Court of Appeals agreed. Both courts thus let the Governor's decision stand. The Supreme Court agreed with both the district court and Colorado Court of Appeals that CMS and CSA had standing to challenge the Governor's decision. **However, the Supreme Court further held that the Governor's opt-out is not a binding interpretation of Colorado law and has no effect other than to opt-out the hospitals from Medicare's physician supervision requirement of CRNAs for reimbursement.** The Supreme Court then explained that the Governor's narrow opt-out decision is only reviewable for a gross abuse of discretion and that the complaint did not allege a gross abuse of discretion or seek an order directing the Governor to act differently. **The Supreme Court let the Governor's narrow opt-out stand but did not decide the broader issue whether Colorado law permits CRNAs to practice without physician supervision. The contrary broader opinions of the lower courts have no**

precedential value given the Supreme Court decision, so this ultimate issue remains undecided subject to the interpretation and arguments of interested parties.

Who is NPATCH?: NPATCH is a healthcare policy task force that is housed in the Division of Professions and Occupations at the Department of Regulatory Agencies (DORA). NPATCH was created in 2009. NPATCH's purpose is to promote public safety and improve healthcare in Colorado by facilitating communication between the practices of nursing and medicine. Its focus on policy is unique within the Division. The Governor appoints the Task Force's 12 members, comprised of five physicians, five nurses and two consumer representatives. One physician is a representative from the Colorado Medical Board, and one nurse is a representative from the State Board of Nursing. The Task Force conducts its business according to the authority granted in its Statute and Bylaws.

CMS Policy: 270.992 CMS and Specialty Society Principles Regarding APN Scope of Practice

Physician-Led Health Care Teams

1. Health care that is effective, efficient, and safe results from the work of patient-centered provider teams – networks of individual providers acting in well-integrated and well-defined relationships. This has always been so for in-patient hospital care, and is increasingly a hallmark of high-quality health care in every medical setting.
2. Provider teams may work in a number of forms, varying with the needs of the patient, the environment in which the care is being provided, and the skills and training of the members of the team. In all cases each provider's work is integrated with the work of others for the betterment of the patient.
3. All effective health care teams respect the specialized skills and knowledge of each participating member; and each member contributes in a defined and coordinated way to achieving optimal care and optimal patient outcomes.
4. The duties, responsibilities, supervisory relationships and boundaries for each member of the team should be explicitly delineated by protocols, medical staff rules, or other similar means.
5. Leadership and overall responsibility for patient care are essential requirements for all effective, efficient and safe medical care. While every provider working in a team contributes a specialized capability, leadership is necessary to integrate the whole to maximize the health benefits to the patient. By the greater depth, length and breadth of their medical education, training, and experience physicians are in most circumstances uniquely qualified for this role.
   Scope of Practice
6. The optimal degree of interaction among the members of a team is environment-dependent. It may vary with the setting, the facility, and the area of health care. An Advanced Practice Nurse, for example, may have less direct physician contact or

supervision in a rural clinic than in a major-city hospital, yet for the same reason require more readily available access to physician expertise. The central criterion is that which provides the best quality and safest care.

7. In no circumstance may Advanced Practice Nurses or other health care professionals practice beyond their license, education, training and experience.
8. Facilities such as hospitals, group practices, out-patient clinics, ACOs and other integrated-care arrangements must establish guidelines or protocols describing the scope of practice for Advanced Practice Nurses and other health care professionals. Such guidelines must be established with participation from physicians having experience and skill in the type of health care being provided. In hospitals the protocols and guidelines should have approval of the medical staff and governing board of the facility.
9. Where facilities establish the scope of practice with guidelines or protocols, the facility must be accountable for the effects of their application.

Nurse Anesthetists

10. **The practice of Nurse Anesthetists is subject to all of the preceding principles, and to additional considerations reflecting the nature of anesthesiology and its diverse applications.**
11. **A nurse anesthetist must be supervised either by an anesthesiologist or by the operating physician for the procedure. If not in continuous physical presence, the supervising physician must be immediately available to attend to the patient when needed.**
12. **In settings without anesthesiologists the supervising physician may be the operating surgeon, obstetrician, or other physician performing the procedure if the facility's medical staff and governing board determine that the supervising physician has the necessary skill and training to provide such supervision.**
13. **If in any case the supervising physician or the nurse anesthetist determines that there is not the necessary expertise within the team to perform a procedure safely, that procedure should not be performed.**

(BOD-1, AM 2012; Reaffirmed, BOD-1, AM 2014)