

CRNA PASS THROUGH MODERNIZATION

THE SOLUTION

Move away from a rigid, outdated volume-based restriction for anesthesia-required procedures.

THE PROBLEM

Current Medicare regulations limit eligibility for CRNA pass-through reimbursement to hospitals performing no more than 800 anesthesia procedures annually. This threshold was last updated more than 20 years ago, using workforce and payment data that no longer reflect current clinical practice, compensation levels or Medicare payment policy. As a result, hospitals face growing financial challenges sustaining anesthesia services, which are essential to maintaining surgical capacity and labor and delivery services. Without updates, these pressures risk further reducing access to care and accelerating the loss of maternity services in rural communities.



BACKGROUND

CMS allows certain rural hospitals and Critical Access Hospitals to receive cost-based reimbursement for services provided by employed or contracted Non-Physician Anesthetists, in lieu of fee schedule reimbursement. To qualify, hospitals must apply for and receive annual

approval from their MAC to “pass through” the fee schedule. If a hospital does not receive approval for a given year, the total costs, charges, and Medicare charges related to any CRNA professional services will be adjusted out of the cost report, thus disallowing any cost-based reimbursement for the CRNA services.

In the CY 2003 Inpatient Prospective Payment System final rule, CMS increased the CRNA pass-through threshold from 500 to 800 procedures. This change was based on data from the American Association of Nurse Anesthetists, which showed that the average annual compensation for a rural CRNA in 2000 was approximately \$141,000. CMS calculated that, under the Physician Fee Schedule, a CRNA would need to perform approximately 800 anesthesia services per year to reach that level of compensation and concluded that the prior 500-procedure cap was insufficient to support a full-time CRNA and therefore inconsistent with maintaining access to anesthesia services in rural hospitals.

During that rulemaking, commenters urged CMS to regularly review and update the CRNA cap to reflect changing market conditions. CMS agreed and pledged to continue monitoring the issue. However, the threshold has not been updated in more than 20 years, despite significant changes in workforce dynamics and financial pressures facing rural hospitals.

FEDERAL: CRNA PASS THROUGH MODERNIZATION

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THE SOLUTION:

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KEY CHANGES SINCE 2003

1. CRNA compensation has increased substantially.
 - a. According to AANA, the average CRNA compensation at CAHs in 2025 is approximately \$253,724, approximately 80 percent higher than the compensation level CMS used to justify the 800-procedure cap.
2. Medicare PFS payments for CRNAs have not kept pace.
 - a. While the compensation needed to attract and retain CRNAs in rural areas has risen significantly, Medicare PFS anesthesia payments – driven by the anesthesia conversion factor – have grown far more slowly.
 - b. In CY 2003, the anesthesia conversion factor was \$17.50. In CY 2025, that number has grown to only \$20.4976 – an increase of approximately 17 percent.

3. CMS expanded what counts toward the cap without recalibration.
 - a. In the CY 2020 Medicare PFS rule, CMS clarified that diagnostic colonoscopies count toward the 800-procedure total, increasing the counted volume without adjusting the underlying threshold.
4. Rural anesthesia demand and case complexity have increased.
 - a. Rural hospitals now perform a broader mix of procedures while continuing to rely heavily on CRNAs as the primary anesthesia workforce.

A CONGRESSIONAL SOLUTION

1. Direct CMS to expand the 800 annual anesthesia procedure cap or remove the outdated limit entirely, allowing all eligible hospitals to qualify for CRNA pass-through regardless of volume.
2. Attach the reasonable cost-based reimbursement cap to the Medicare Economic Index to ensure it keeps pace with market conditions.
3. Direct MedPAC or the Government Accountability Office to review the inclusion of on-call CRNA costs on the cost report and recommend sustainable reimbursement solutions.

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