American Association of
NURSE ANESTHESIOLOGY

December 4, 2023

Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
7500 Security Boulevard, Baltimore,
Maryland 21244

RE: Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Dear Mr. Tsai:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to respond to the agency's request for comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. We are firmly committed to working with the agency and other healthcare stakeholders to help achieve our common goals of increasing access to healthcare, advancing health equity, reducing regulatory burdens, and making healthcare more affordable for all Americans, including in the areas of mental health and substance use disorders (SUD). The AANA makes the following comments:

- CRNAs Role in Mental Health and SUD Treatment
- Require CRNAs to be included in all Health Carrier Network Plans, to Help Ensure Network Adequacy, Access, and Affordability to Patients
- Support Promulgation of a Regulation on PHS Section 2706 (a) and Medicaid Plans Should Avoid Violation of Federal Nondiscrimination Laws

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 61,000 CRNAs and SRNAs, representing about 86 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. For further information, see: https://www.aana.com/about-us.

AANA Comment: CRNAs Role in Mental Health and SUD Treatment

We support the agency's continued interest in gaining stakeholder recommendations on increasing patient access to care, including access to mental health and substance use disorder (SUD) treatments. Medicaid fills a critical role in supporting access to services and treatment for millions of individuals struggling with these conditions. However, during the current mental health and substance use

disorder crises, patients are finding access to these treatments more difficult to attain than access to medical services.

The Mental Health Parity and Addiction Equity Act was enacted to ensure that individuals with group or individual insurance coverage who seek treatment for covered mental health conditions or SUDs do not face greater barriers to accessing these benefits than they would face when seeking coverage for medical or surgical treatments. It is important that patients can receive this needed care from the providers who deliver them. The AANA shares the agency's concern about the rise in the number of patients who need treatment for mental health and SUDs as well as the increase in opioid drug use, abuse and deaths. We are committed to working collaboratively with your agencies to achieve comprehensive solutions to end these crises in this country. CRNAs personally administer more than 50 million anesthetics, pain management and related services to patients in all types of settings each year in the United States. In addition to their extensive anesthesia experience, many CRNAs also provide medically necessary services within their scope of practice and standards of nurse anesthesia practice in the fields of mental health, pain management and substance use disorder treatments. CRNAs are uniquely skilled to provide both acute, interventional, and chronic pain management in a patient centered manner across the pain continuum in all clinical settings.[1] CRNAs possess a strong foundation in nursing, critical care, anesthesia delivery, pain management, advanced physiology/pathophysiology, pharmacology, and advanced physical assessment - all of which are critical to safely delivering patient care.

Many patients rely on CRNAs to treat their pain and CRNAs have been on the front lines of developing novel non-opioid based pain treatments. We support maximum flexibility in allowing pain treatment plans that rely on the clinical judgment of the practitioner directing care. CRNA chronic pain management practitioners address chronic pain using a multimodal approach that includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies to help decrease reliance on opioids. As the risk of opioid dependence and addiction begins with the first exposure, CRNAs promote comprehensive multimodal pain management in addition to Enhanced Recovery After Surgery (ERAS®) protocols as non-opioid alternatives to treat pain in all

[1] AANA Chronic Pain Management Guidelines, September 2021, available at: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/chronic-pain-management-guidelines.pdf?sfvrsn=d40049b1_8, AANA Regional Anesthesia and Analgesia Techniques - An Element of Multimodal Pain Management Guidelines, https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/regional-anesthesia-and-analgesia-techniques-an-element-of-multimodal-pain-management.pdf?sfvrsn=8aac5eb1_6, and AANA Guidelines on A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/a-holistic-approach-to-pain-management-integrated-multimodal-and-interdisciplinary-treatment.pdf?sfvrsn=f40049b1_4

clinical settings. Many pharmacologic treatments can be used to manage pain. While each nonopioid alternative has its own indications and risks, some are likely to be as effective as opioids or more so for reducing pain associated with the conditions for which they are indicated and when used appropriately, carry lower risk of adverse outcomes. Careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse. Using specific protocol-driven enhanced recovery after surgery pathways improves patient outcomes by reducing the patient's stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient's pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.

In the mental health arena, CRNAs are educated and trained to administer ketamine both for sedation and general anesthesia, chronic pain management and ketamine infusion therapy for psychiatric disorders and chronic pain. This therapy has been shown to have antidepressive properties and is increasingly becoming used to treat psychiatric disorders, including major depressive disorder (MDD), bipolar disorder, treatment-resistant depression, and post-traumatic stress disorder (PTSD). AANA also supports a patient-centered, interdisciplinary approach to managing patients who suffer from psychiatric disorders and may benefit from ketamine infusion therapy and practice in accordance with professional ethics, scope and standards of practice, sound professional judgment, available evidence, interests of the patient, and applicable law. When administering ketamine for the treatment of psychiatric disorders, CRNAs collaborate with healthcare professionals whose practice includes focusing on and diagnosing mental health and psychiatric disorders within their professional and state scope of practice.[2]

AANA Comment: Require CRNAs to be included in all Health Carrier Network Plans, to Help Ensure Network Adequacy, Access and Affordability to Consumers

This request for comment asks for information on measures that should be considered regarding provider network composition and standards for provider network admission. Ensuring meaningful access to mental health and substance use disorder care is vital to addressing the nation's mental health and substance use disorder crisis. A key component of access is the availability of an adequate number of appropriate providers within a plan's network. AANA believes that patients benefit the greatest from a health care system where they receive easily accessible care from an appropriate

[2] AANA and APNA Joint Position Statement on Ketamine Infusion Therapy for Psychiatric Disorders (2019), https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/apna-aana-joint-statement-on-ketamine.pdf?sfvrsn=8ecfb9bb_10

choice of safe, high quality and cost-effective providers, such as APRNs and CRNAs. Nonphysician providers, such as CRNAs, are an important type of provider with an integral role in providing safe and high-quality care in the health care marketplace. We support the requirement for health carriers to maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. We recognize the importance of network adequacy among health plans. We request that CRNAs be required to be included in all health carrier network plans, which will help ensure network adequacy, access, and affordability to consumers. Eliminating barriers to the use of APRNs in healthcare delivery, including those barriers that arise in public and private health plans, is consistent with the agency's goals of increasing patient access to high quality cost-effective healthcare.

AANA Comment: Support Promulgation of a Regulation on PHS Section 2706 (a) and Medicaid Plans Should Avoid Violation of Federal Nondiscrimination Laws

AANA supports the agency's request for information that can help identify potential parity violations regarding Medicaid managed care arrangements, Medicaid ABPs, and CHIP. Ensuring compliance with federal parity requirements in Medicaid and CHIP is fundamental to improving access to care for enrollees who need MH and/or SUD treatment. However, just meeting parity, as this request for comment recommends, isn't enough to ensure patient access to these services. The agency needs to take further steps to meet the critical need to treat these and other conditions. AANA recommends promulgation of a regulation on provider nondiscrimination to help enforce discriminatory policies and that these plans do not institute pass policies that violate federal provider nondiscrimination laws.

Currently, the United States is experiencing a mental health and substance use disorder crisis. Patients are too frequently discouraged from seeking care for mental health and substance use disorders because of barriers, both inside and outside of the health care system, such as discrimination, stigmatization, inability to find an in-network provider accepting new patients, cost, and geography. This is also an issue that providers, such as CRNAs, face when they deliver anesthesia, pain management and related services, some of which are in the mental health and substance use disorder spheres.

CRNAs, and other advanced APRNs acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to reimbursement and participation in both public and private insurance networks and coverage of procedures that are clearly included in their state scope of practice. Such discrimination impairs access to needed healthcare services, consumer choice and competition, and impairs efforts to control healthcare cost growth.

Discrimination by health plans based on a provider's licensure is illegal. Provider nondiscrimination helps to promote consumer choice, competition, innovation and lower costs, and is found in both the

federal Medicaid statute and in the Public Health Service Act. The federal Medicaid provider nondiscrimination law states, "An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification."[3] The federal provider nondiscrimination law, [Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5]),[4] prohibits private health insurer discrimination on providers based on their licensure, which promotes access to care by allowing consumers to select the provider of their choice.

Unfortunately, there are numerous examples of health plans discriminating against providers, such as CRNAs. In the absence of meaningful enforcement of the statute, health plans and insurers have refused to allow CRNAs members in their networks or to contract with them, have reimbursed our members unequally for the same high-quality care as our physician colleagues, have imposed supervision requirements beyond what is required by state and federal laws, and have not allowed APRNs to participate in value-based care programs solely based on licensure. Meaningful implementation of this law is vital in protecting CRNAs against these types of discrimination.

Congress has made clear that federal implementation to date has not been sufficient. In December 2020, the *Consolidated Appropriations Act of 2021* was signed into law, which included the *No Surprises Act*. Section 108 of the *No Surprises Act* requires the Secretaries of the Departments of Health and Human Services, Labor, and Treasury to issue a proposed rule no later than January 1, 2022. Based on the regulatory timeline required under Section 108, a final rule should have already been promulgated to permanently implement these protections again provider discrimination. We are very concerned that numerous deadlines have passed to promulgate this rule given the fact that the agencies were mandated to do this in a specific timeframe. We strongly encourage the agencies to release this rule as soon as possible to help patients get the care they need and deserve.

[3] 42 CFR § 438.12(a)(1)

[4] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

AANA appreciates the opportunity to comment on this request. Should you have any questions regarding our comments, please feel free to contact AANA Senior Associate Director, Federal Regulatory and Payment Policy, Randi Gold at rgold@aana.com.

Sincerely,

Dru Riddle, PhD, DNP, CRNA, FAAN

AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
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