American Association of
NURSE ANESTHESIOLOGY

February 8, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4201–P
PO Box 8013
Baltimore, MD 2124

RE: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Ms. Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to submit comments to the *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications* proposed rule. The AANA makes the following comments and recommendations:

I. Include CRNAs and Account for All CRNA Sub-Specialties and Dual Degrees in MA Provider Directories
II. Permanently Remove Unnecessary Regulatory Barriers That Limit Access to Care and Health Equity for Medicare Advantage Beneficiaries
III. Reduce Regulatory Barriers for CRNAs to Increase Access to Anesthesia Care in Rural Communities
IV. MA Plans Should Not Rely on Only Using Criteria from Medical Societies When Creating Internal Coverage Criteria to Make Medical Necessity Determinations

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing about 90 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.

I. A. Health Equity in Medicare Advantage (MA) (§§ 422.111, 422.112, and 422.152)

A. AANA Recommendation: Include CRNAs and Account for All CRNA Sub-Specialties and Dual Degrees in MA Provider Directories

The current MA provider directory model contains an array of specific required information known as required provider directory data elements. We believe it is imperative that CMS ensure that MA provider directories do not inadvertently treat CRNAs and Advanced Practice Registered Nurses (APRNs) differently from physicians. In doing so, CMS should ensure that they are not discriminating against provider types based on licensure[1] and guarantee that patients can find and locate an APRN just as easily as they can to find a physician.

We also ask that CMS also assure that CRNA services and subspecialties also be included in the directories, so CRNAs are readily and easily locatable in the directory for their services. In addition to providing anesthesia services, CRNAs also provide acute, chronic, and interventional pain management services. We note that patients will not have complete, accurate, and up-to-date information if CRNAs are not listed and recognized for all the services they provide a directory despite those services being within their scope of practice in a given state. If a particular subspecialty or service is not listed for CRNAs, it could open up commercial payors to use this as a reason for not including CRNAs in their networks or not reimbursing for particular services. Moreover, including CRNA sub-specializations in the directory reinforces and promotes CMS's strategic plan to advance health equity as it helps identify providers ensuring access to the closest available healthcare services. Should CRNAs not be included, patients will get an incomplete and inaccurate list of providers available for services, which hampers improving access to medically necessary anesthesia and pain management services, especially in rural and underserved areas. The directory should also account for CRNAs who hold dual degrees as well. For instance, a CRNA who also is certified as a Nurse Practitioner should be able to have both designations accounted for. Furthermore, the information displayed for CRNAs should be equivalent to that displayed for physicians including recognizing CRNA board certifications if they include medical board certifications.

B. AANA Request: Permanently Remove Unnecessary Regulatory Barriers That Limit Access to Care and Health Equity for Medicare Advantage Beneficiaries

We applaud CMS' work to advance health equity across its programs and pursue a comprehensive approach to advancing health equity for all, including those in rural and underserved areas. The AANA supports the agency's commitment to ensure that Medicare Advantage beneficiaries have access to affordable, high value and high quality healthcare. We ask that as the agency continues to explore policies in Medicare Advantage plans, do not impose any barriers to those providers participating in those plans. The current Public Health Emergency (PHE) has shown the important need for health care professionals to work to the top of their scope to care for patients and highlights the important role that CRNAs play in our healthcare system, especially when workforce barriers to practice are eliminated.

[1] 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) and Consolidation Appropriations Act, DIVISION BB—PRIVATE HEALTH INSURANCE AND PUBLIC HEALTH PROVISIONS, Sec. 108,

In their roles as Advanced Practice Registered Nurses (APRNs), many CRNAs have assisted on the frontlines of the pandemic to provide expert care to the sickest patients. We have seen barriers to CRNA practice removed at both the state and federal levels, allowing CRNAs to provide critical, lifesaving care to patients. CRNAs are practicing independently, providing invaluable support by using their expertise in rapid systems assessment, airway management, managing ventilators, vascular volume resuscitation, placing of invasive lines and monitors, overseeing complex hemodynamic monitoring, emergency preparedness, and resource management. Data from CMS showed that CRNAs are one of the top specialties serving the most Medicare beneficiaries during the first three months of the pandemic (March – June) in 2020[2]. Permanently removing barriers to care will benefit patients and the larger healthcare system. Given the important role that CRNAs are playing in providing care during the pandemic through the removal of unnecessary rules, the AANA supports a thorough and evidence-based approach to ensure that any rules that have been suspended during the PHE are only re-enacted if they serve a meaningful purpose in healthcare delivery.

In addition, as the agency works to promulgate a rule implementing the provider nondiscrimination provision in the bipartisan enacted Consolidated Appropriations Act of 2021, we urge prompt promulgation of this rule. Meaningful implementation of this provision is important to protect CRNAs and other APRNs from discriminatory practices in the private insurance market, including MA plans. 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 participation in and coverage of procedures that are clearly included in their state scope of practice. Such discrimination violates the federal provider nondiscrimination law and also impairs access to needed healthcare services, consumer choice and competition, and impairs efforts to control healthcare cost growth.

We strongly encourage the rulemaking to:
• Address parity in reimbursement rates for all types of providers practicing within their state licensure and scope of practice laws, to ensure providers working within their state scope are reimbursed equitably for the same high-quality service.
• Prohibit health plans, insurers, and payers from engaging in prohibited contracting practices. This includes the practice of excluding a specific class of provider from network participation based solely on their license.
• End the discriminatory practice where a health plan issuer places additional requirements on providers, beyond their state licensing requirements, for that provider to participate in the health plan issuer's network. This includes supervision requirements or requirements for additional certifications or training, beyond state licensing requirements

Issuing a regulation on provider nondiscrimination will help dissipate any unintended barriers to the use of CRNA services and ensure that CRNA are practicing at their full professional education, skills, and scope of practice. It will also help the advancement of health equity in all plans, including Medicare Advantage.

C. <u>AANA Recommendation: Reduce Regulatory Barriers for CRNAs to Increase Access to Anesthesia Care in Rural Communities</u>

[2] CMS Report January 2021 "Putting Patients First: The Center for Medicare and Medicaid Services Record of Accomplishment from 2017-2020."

As CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities, it vital that the agency should promote access to the use of CRNA anesthesia services in rural America. Furthermore, the agency should ensure that future policy does not create unintended barriers to the use of CRNA services and that CRNA are practicing at their full professional education, skills, and scope of practice. Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, which has been proven through decades of scientific research.

Rural hospitals are vital to providing health care to their communities and the increasing closure of rural hospitals limits access to care, produces long trips for emergency care and causes an increase in negative health outcomes for patients living in rural areas.[3] According to the Center for Healthcare Quality and Payment Reform, over 150 rural hospitals across the country closed between 2005 and 2019 and an additional 19 rural hospitals closed their doors in 2020[4]. In addition, more than 600 rural hospitals, which is about 30% of all rural hospitals in the United States, are at risk of closing in the near future[5].

CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide obstetrical, surgical, trauma stabilization, and pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and can provide every aspect of the delivery of anesthesia services, from pre-anesthesia patient assessment, to administering the anesthetic, and monitoring and interpreting the patient's vital signs and managing the patient throughout the surgery.

However, anesthesia services are currently underfunded, and this disproportionate pay affects patient access to anesthesia care, especially in rural and underserved areas where CRNAs predominate. A study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.[6] The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[7] This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. In addition, a 2007 Government Accountability Office (GAO) study found that Medicare paid 67 percent of what private insurers paid for

[3] "The Health 202: Congress is throwing a lifeline to struggling rural hospitals." The Washington Post, June 29, 2021.
[4] Center for Healthcare Quality and Payment Reform, "Rural Hospitals at Risk of Closing." (July 2022) https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

[5] Center for Healthcare Quality and Payment Reform, op cit.

[6] Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

[7] Liao, op cit.

anesthesia services.[8] Furthermore, the study also reported that CRNAs are the predominant anesthesia professional where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less, indicating that CRNAs are providing services in areas in which there is a greater proportion of Medicare beneficiaries compared to private payor payment, and there is less private payment to make up for the lower payment by Medicare. Such a disproportion in payment places a financial strain on healthcare professionals and facilities, shifts Medicare costs onto others, and can threaten beneficiary access to care.

Research evaluating type of facility, size, and anesthesia staffing by rural location shows that 55.5% of small rural hospitals and 61.2% of rural ambulatory surgery centers were predominately staffed by CRNAs.[9] Further research has shown that there is significant geographic variation in anesthesia provider supply and lower supply in rural communities raises concerns about access to procedures that require anesthesia in rural areas.[10] The study found that enforcing state policies related to CRNA practice, such as less restrictive scope of practice regulations, were consistently correlated with a greater supply of CRNAs, especially in rural counties.[11]

II. E. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, and 422.138)

AANA Recommendation: MA Plans Should Not Rely on Only Using Criteria from Medical Societies When Creating Internal Coverage Criteria to Make Medical Necessity Determinations

The AANA recognizes that there are some Medicare Part A or Part B benefits that do not have applicable Medicare National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or specific traditional Medicare coverage criteria in regulation for Medicare Advantage (MA) plans to follow when making medical necessity determinations. It is understandable that without this type of information, MA plans would then have to create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available. We support the proposed rule's requirement that MA organizations must follow similar rules that CMS and Medicare Administrative Contractors (MACs) must follow when creating NCDs or LCDs by providing publicly available information that discusses the factors the MA organization considered in making coverage criteria for medical necessity determinations.

The AANA cautions that during the process of creating internal coverage criteria, MA plans should not rely only on guidelines or clinical literature from physicians or medical societies and should make sure to include information from the nursing field, including CRNAs as well. CRNAs are advanced practice registered

[8] U.S. Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15. http://www.gao.gov/new.items/d07463.pdf.

[9] Coomer N. et al. (2019). Anesthesia staffing models and geographic prevalence post-Medicare CRNA/physician exemption policy. *Nursing Economic$, 37*(2), 86-91. https://search.proquest.com/openview/3f55b0d94533f910b7c0c1dc5d7202bc/1?pq-origsite=gscholar&cbl=30765

[10] Martsolf, G et. Al. (2019) Relationship Between State Policy and Anesthesia Provider Supply in Rural Communities. *Medical Care*, *57*(5):341:347. https://www.ncbi.nlm.nih.gov/pubmed/30870391

[11] Martsolf, op cit.

nurses (APRNs) who personally administer more than 50 million anesthetics and pain management services to patients each year in the United States and provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals. Use of only physician-centric summaries of evidence during the development of the internal coverage criteria does not reflect all of the types of healthcare professionals who currently provide these services. Inclusion of all types of healthcare professionals would help increase transparency in the development of this criteria while also ensuring there are no barriers to patient access to care.

The AANA appreciates the opportunity to comment on this proposed rule. We are committed to working with the agency and other healthcare stakeholders to help achieve our common goals of increasing access to healthcare, advancing health equity, increasing innovative healthcare models, reducing regulatory burdens on stakeholders, empowering consumers and making healthcare more affordable for all Americans. Should you have any questions regarding our comments, please feel free to contact AANA Senior Associate Director Randi Gold at rgold@aana.com.

Sincerely,

Angela Mund, DNP, CRNA
AANA President

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