American Association of
NURSE ANESTHESIOLOGY

October 17, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C., 20201

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave N.W.
Washington, D.C., 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act

Dear Secretaries Becerra, Yellen and Acting Secretary Su:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to submit comments to this proposed rule. 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. The AANA makes the following comments and recommendations:

- CRNAs Role in Mental Health and SUD Treatment
- Support Promulgation of a Meaningful Regulation on PHS Section 2706(a)

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.

The agencies have missed numerous deadlines to issue this rule, the latest being the August 2023 deadline that was published in the Spring 2023 Unified Agenda of Regulatory and Deregulatory Actions. We are greatly disappointed that the agencies have failed to meet the statutory deadline of January 1, 2022 for this rulemaking. As noted in this proposal, the Agencies held a listening session on January 19, 2022, regarding the implementation of provider nondiscrimination, and have yet to promulgate this rule. Almost 2 years have passed since the congressionally mandated deadline for the

implementation of this provision. Therefore, it is incumbent upon the agencies to swiftly issue a proposed rule pursuant to Congress' directive.

The need for prompt rulemaking is critical because many private health insurers continue to discriminate against health care providers based on their licensure. Without an enforceable rule, many APRN providers face undue barriers to providing care, based on discriminatory policies from insurers.

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. 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 have the ability to receive this needed care from the providers who deliver them.

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. 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 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

[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

physiology/pathophysiology, pharmacology, and advanced physical assessment - all of which are critical to safely delivering patient care. 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.

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 through the use of 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 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 also 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 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: Support Promulgation of a Regulation on PHS Section 2706 (a)

We are pleased to see the agency is asking for additional stakeholder feedback on development of the regulation on the 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).[3] This important law prohibits private health insurer discrimination based on their licensure, which promotes access to care by allowing consumers to select the provider of their choice. We believe this RFI in the proposed rule is an important step in getting this long-awaited rule promulgated. We have been very vocal over the last few years about the importance of promulgation of this regulation. Removing the ability for health plans to discriminate against CRNAs based on licensure will allow them to practice to the full extent of their education, training, and certification, and access to the integral roles discussed in the previous section.

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 participation in insurance networks and coverage of procedures that are clearly included in their state scope of practice. Such discrimination impairs access to needed healthcare services,

[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

[3] 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."

consumer choice and competition, and impairs efforts to control healthcare cost growth. Meaningful implementation of this law is vital in protecting CRNAs against these types of discrimination.

We appreciate and support the agency's efforts to remove barriers that limit healthcare professionals, such as CRNAs, from practicing at the top of their license and scope of practice. Across the country, CRNAs can administer all levels of anesthesia in every state – local, sedation, regional and general. Regardless of the provider who is performing and assumes responsibility for the procedure, such as the MD/DO, dentist, or podiatrist, the CRNA is responsible and accountable for the anesthesia care provided to the patient. CRNAs also select, order, prescribe, and administer medications, including controlled substances.

In 2010, Congress passed this law which prohibits private health plans from discriminating against qualified licensed healthcare professionals based on their licensure. Discrimination by health plans based on a provider's licensure is illegal. However, since its passage, this provision has not been implemented through the rulemaking process making enforcement of this law difficult. The latest action taken on this issue was sub-regulatory guidance in the form of a 2015 Frequently Asked Questions (FAQ) document. The FAQ stated, "Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision."

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 in order to help patients get the care they need and deserve.

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. Based on the provider nondiscrimination law, these actions are illegal and should be stopped. One prime example of this discriminatory behavior occurred earlier this year when Cigna recently announced their intention to

decrease reimbursement for all CRNA non medically directed QZ services to 85% of the fee schedule, despite the fact that CRNAs are able to bill 100% of the Medicare fee schedule and without regard to outcomes or state scope, based solely on their licensure. This affected CRNAs practicing in all types of facilities nationwide and certainly will reduce patient access to this care. This is why promulgation of a rule is so vital.

As staff within the Departments of Health and Human Services, Labor and Treasury continue promulgation of a regulation on provider nondiscrimination, we make the following recommendations to ensure that further discriminatory policies against CRNAs are prevented:

• Prohibit health insurers, health plans and payors from establishing varying reimbursement rates for CRNAs practicing within their state licensure and state scope of practice laws to ensure they are reimbursed equitably with their physician counterparts for the same services.

• Prohibit health insurers, health plans and payors from denying coverage of services and procedures within the CRNA scope of practice.

• Prohibit health insurers, health plans and payors from imposing requirements for supervision or additional certification or training beyond state licensing requirements.

• Prohibit health insurers, health plans and payors from issuing policies that deny CRNA access to insurance networks and advanced payment models and prohibit geographic limitations on provider network participation.

• Create a timely, organized, and efficient notice and grievances process for providers to allow for resolution of their complaints.

Proper implementation of the provider nondiscrimination law is crucial because health plans have latitude to determine the quantity, type, and geographic location of healthcare professionals they need to ensure availability of healthcare benefits to their enrollees. AANA deems it discrimination if health plans or health insurers have a policy that reimburses unequally for the same services provided by different provider types while achieving the same high quality outcomes**.** While health plans might believe this is a cost-effective way to save money and lower health care costs, this would direct cases to more expensive providers, such as anesthesiologists, leading to impaired access, increased costs and lower quality of care.

CRNAs are the clinicians of choice for many patients, especially those in rural and underserved areas who are adversely affected by lack of access to care even if they have coverage. Rural hospitals are essential 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.[4] Over 130 rural hospitals have closed in the U.S. since

AANA
American Association of
NURSE ANESTHESIOLOGY

2010. CRNAs play a central role in assuring that rural America has access to critical anesthesia services, allowing these facilities the capability to provide many necessary procedures. 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. We urge your departments to promulgate a strong and enforceable provider nondiscrimination rule that protects the needs of patients and consumers, allows access to an ample number of appropriate providers within a plan's network and enables CRNAs to practice without having to face barriers from health plan policies and practices. We have already seen the harm caused by insurers issuing discriminatory policies against all APRNs, including CRNAs. For example, Cigna lowered reimbursement for all CRNA QZ services nationwide to 85% of the fee schedule, even though CRNAs are able to bill 100% of the Medicare fee schedule and without regard to outcomes or state scope. Their reasoning for this decrease was based solely on licensure. In addition, an insurer in Arkansas only reimburses nurse practitioners (NPs) for services for patients with presenting problems of low to moderate severity. This restricts NPs from providing services within their scope of practice and limits access to care for vulnerable patients, including for patients in need of mental health or behavioral health care. If additional insurers follow on this path, we will see patients unable to receive the care they need, including treatment for mental health and SUD services.

We cannot stress enough the urgency in making sure this rule is promulgated. AANA appreciates the opportunity to comment on this proposed rule. 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
Ingrida Lusis, BA, AANA Chief Advocacy Officer
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy