June 10, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9942-NC
PO Box 8016
Baltimore, MD 21244-8016

RE: CMS-9942-NC: Request for Information Regarding Provider Nondiscrimination

Dear Ms. Tavenner:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on CMS-9942-NC: Request for Information Regarding Provider Nondiscrimination.

The issues addressed in our comment are outlined as follows:

I. Background of the AANA and Certified Registered Nurse Anesthetists

II. Appropriate Enforcement of the Provider Nondiscrimination Law Promotes Consumer Choice and Market Competition, Advancing Patient Safety Innovations and Cost-Efficiency in the Public Interest

III. A Healthy Marketplace for Healthcare Services Benefits from Common Understanding of Terms Used in the Provider Nondiscrimination Statute, which Agencies Have Power to Clarify and Communicate

IV. Types and Examples of Provider Discrimination
I. BACKGROUND OF THE AANA AND CRNAS

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists. AANA membership includes nearly 47,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 34 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery
model.\(^1\) Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.\(^2\)

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.\(^3\) Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities and the offices of dentists, podiatrists, and all types of specialty surgeons. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.\(^4\)

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.\(^5\)

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1. Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economics*. 2010; 28:159-169, available at [http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf).
II. APPROPRIATE ENFORCEMENT OF THE PROVIDER NONDISCRIMINATION LAW PROMOTES CONSUMER CHOICE AND MARKET COMPETITION, ADVANCING PATIENT SAFETY INNOVATIONS AND COST-EFFICIENCY IN THE PUBLIC INTEREST

The AANA thanks the Departments of Health and Human Services, Labor and Treasury (the Departments) for requesting comments on all aspects of the interpretation of the federal provider nondiscrimination provision in 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”) which took effect January 1, 2014. We commend the agencies for seeking comment, as we and the Senate Appropriations Committee have communicated numerous concerns with respect to the “Frequently Asked Questions” (FAQ) document that the Departments of Labor, Health and Human Services and Treasury issued on April 29, 2013. Among other outcomes, the FAQ has driven plans to actually and specifically discriminate against qualified licensed providers with respect to participation and coverage, which is the opposite of what Congress intended by enacting the statute.

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to high quality healthcare, market competition and cost efficiency, health insurance marketplaces, health insurers and health plans must all avoid discrimination against qualified, licensed health care professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider

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6 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.”

nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose “any willing provider” requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

III. A HEALTHY MARKETPLACE FOR HEALTHCARE SERVICES BENEFITS FROM COMMON UNDERSTANDING OF TERMS AND CONCEPTS USED IN THE PROVIDER NONDISCRIMINATION STATUTE, WHICH AGENCIES HAVE POWER TO CLARIFY AND COMMUNICATE

The provider nondiscrimination statute includes several critical terms and concepts that Congress did not expressly define. The agencies can and should define these terms clearly so that all marketplace participants – health insurers, healthcare professionals, and patients – are made aware of their rights and duties as part of the organization of an orderly and predictable marketplace for high quality healthcare delivery. The most critical terms and concepts in the statute are “nondiscrimination” and “discriminate,” what types of plans the statute covers, the clarification that the statute does not require plans to cover services by “any willing provider,” the issue that whether a plan publishes discriminatory terms and conditions that a provider nonetheless accepts somehow exempts the plan from enforcement and penalties under the statute, and the circumstances under which plans and the Secretary might vary prices. We will examine these issues in turn.
AANA Request: Prohibited Discrimination Includes Plan Policies that Reimburse Qualified, Licensed Provider Types Different Rates, or Exclude Such Providers by Class, for Delivering the Same High-Quality Service

As the Departments are aware, the federal nondiscrimination provision states that “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.” It also states that “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.” The Departments should clarify that Section 2706 intends to protect patient choice and access to a range of beneficial providers and prevent discrimination and also does not permit health insurance plans to discriminate against an entire class of health professionals, such as CRNAs. In enacting Section 2706, Congress did not describe at length what constitutes “nondiscrimination,” or what it means for a plan to “discriminate” against qualified providers solely on the basis of their licensure. In the report accompanying the FY 2014 Labor-HHS-Education Appropriations legislation, the Senate Appropriations Committee made clear what these terms are not – namely, they are not accurately rendered in the agencies’ April 2013 FAQ document, which we agree has contributed to harmful misunderstanding and misinterpretation of provider nondiscrimination. Relying on the plain English definitions of these terms, well within the plain text of the statute, we ask the Departments to list the following practices as discriminatory and in violation of Section 2706.

We believe it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Paying one qualified provider type a higher rate than another for providing the same high quality service offers a powerful incentive to increase healthcare costs without improving healthcare quality or access, by helping to steer healthcare delivery to more expensive providers. For example, in the delivery of anesthesia services, the labor costs of
anesthesiologists are approximately three times higher than those of CRNAs. Quality of care is high and continually improving, and patient outcomes by provider type are similarly excellent as measured by the published research we have already shown. The choice of discriminating in coverage or reimbursement against qualified licensed providers solely on the basis of licensure therefore leads to impaired access, increased costs and lower quality of care.

If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. For example, if a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone.

Ensuring that health plans and health insurers adhere to this nondiscrimination law would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness. These priorities correspond with the principles advocated by the AANA, which are to provide safe, high-quality and cost effective anesthesia care for patients. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

IV. TYPES AND EXAMPLES OF PROVIDER DISCRIMINATION

AANA Request: Reimburse CRNAs and Physicians the Same Amount When the Same Healthcare Services are Provided to Patients

Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services.

The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989. The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider’s state scope of practice, states, “Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished.” The final rule also states, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.” The agency also said in the rule’s preamble, “In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states.” Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. We believe that this is clearly prohibited provider discrimination, because the coverage differentials are so evidently based on the difference in licensure between CRNAs and anesthesiologists and have no relation to issues of quality or performance. This discrimination, which we outline below, limits or altogether denies patient choice and access to beneficial, safe, and cost-efficient healthcare, impairing competition, patient access to care, and optimal healthcare delivery. Thus, we ask the Departments to interpret and enforce the provider nondiscrimination provision appropriately and

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11 42 C.F.R. § 410.69(a).
12 Ibid.
effectively, as a method to increase access to qualified providers by reimbursing CRNAs and physicians the same amount when the same types of services are provided to patients.

*Examples where CRNAs are not Reimbursed, but Physicians Are, for Providing the Same High Quality Services*

Below are a few examples from our membership where health plans do not reimburse CRNAs for certain anesthesia services but they do reimburse physicians for the same services:

- **As of April 2012,** Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay anesthesiologists for these same services.\(^{13}\) Specifically the policy states, “BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC.”\(^{14}\)

- **In 2013,** Anthem Blue Cross Blue Shield of Virginia changed its plan to contract with and credential certain non-physician providers including CRNAs. The language from the policy says, “After careful analysis, we’ve made a business decision to postpone the credentialing/contracting requirements and changes impacting NPs, PAs and CRNAs so we can better focus our internal efforts on upcoming federal requirements and provider initiatives such as ICD-10.”\(^{15}\)

- **CoOpportunity Health,** a nonprofit health insurance cooperative serving Iowa and Nebraska, currently will not reimburse CRNAs for at least two procedures performed to treat chronic pain – sacroiliac joint pain treatment procedures and epidual steroid injections (ESI) for low back pain. These services are within CRNA scope of practice in both states. The language from the sacroiliac policy states, “Sacroiliac joint injections are not covered when performed: A. Without guidance by real-time fluoroscopic

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\(^{14}\) Ibid.

imaging; and B. By clinicians other than physicians.”

The language from the ESI policy states, “Indications not covered: 1. For non-radicular back pain. 2. Without guidance by real-time fluoroscopic imaging; and 3. By clinicians other than physicians.”

- HealthPartners, a health plan serving Minnesota, North Dakota, South Dakota and Wisconsin, also will not reimburse CRNAs for ESI and sacroiliac joint pain treatment procedures. HealthPartners’ policy language is the same as the language used in CoOpportunity’s policy language stated above. As the Institute of Medicine report entitled “Relieving Pain in America” states, many more healthcare professionals are needed to assess and treat pain. The report also states that 100 million Americans suffer from chronic intractable pain that costs $635 billion each year in medical treatment and lost productivity. Policies that do not reimburse certain types of providers who can perform these services ultimately threaten to diminish the access to and robustness of a care modality already identified as inadequate in volume and number to serve the demands of the population.

**Examples where CRNAs Reimbursed at Systematically Lower Rates than Physicians for Providing the Same High Quality Services**

Below are a few examples from our membership where health plans reimburse CRNAs at a lower rate than physicians for performing the same anesthesia services:

21 Ibid.
• Effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, “Physician conversion factor is $55.10. Certified Registered Nurse Anesthetist conversion factor is $46.84.” When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent of the physician rate, Regence stated in a letter to a CRNA that the decision was in part “based on the difference in education, training and scope of practice” between physician and non-physician providers. Regence also said its policy was in conformance with the Departments’ joint guidance on PHS Act Section 2706 (a) FAQs.

• After decades of CRNAs requesting direct reimbursement for anesthesia services from Blue Cross Blue Shield of Alabama, this health plan began offering a new network contract for CRNAs across all its health plans in October 2013. Prior to this date, Blue Cross Blue Shield of Alabama did not pay CRNAs at all, and 100 percent of the fee went to the anesthesiologist. Effective January 1, 2014, Blue Cross Blue Shield of Alabama began paying CRNAs directly, but at a reduced rate relative to an anesthesiologist. The new payment policy splits reimbursement 65/35 in favor of physicians in cases where they are medically directing services performed by CRNAs, even though the peer-reviewed medical literature and AANA member surveys find that anesthesiologist medical direction frequently lapses. Furthermore, in cases where CRNAs provide and submit claims for non-medically directed services, Blue Cross Blue Shield of Alabama reimburses them at 70 percent of the anesthesiologist fee for providing the same high quality service, with no justification for the reduction.

• As of 2011, Blue Cross Blue Shield of Illinois “implemented a fee schedule change that will provide reimbursement based on the type of rendering provider indicated on the 

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claim.” In this fee schedule change, physicians receive 100 percent and CRNAs receive 85 percent of the applicable physician fee schedule for services provided.

- Also in 2011, Horizon Blue Cross Blue Shield of New Jersey changed its anesthesia reimbursement policy so CRNAs receive 50 percent of the applicable physician fee schedule in cases where they are medically directed by an anesthesiologist. Horizon also will not reimburse and will deny any claims submitted by CRNAs who perform procedures without medical direction of a physician.

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who otherwise might be forced to travel long distances for these essential care.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with public interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient access to

a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

We thank you for the opportunity to comment on this request for information. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Dennis C. Bless, CRNA, MS
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
    Frank J. Purcell, BA, AANA Senior Director of Federal Government Affairs
    Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy