American Society of Anesthesiologists™

1061 American Lane | Schaumburg, IL 60173-4973 | (847) 825-5586
905 16th Street N.W. | Washington, D.C. 20006 | (202) 289-2222

VIA Electronic Submission to http://www.regulations.gov

March 3, 2022

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS–4192–P
Mail Stop C4–26–05
7500 Security Boulevard, Baltimore
MD 21244–1850

RE: **[CMS 4192-P]** Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure:

On behalf of our more than 55,000 members, the American Society of Anesthesiologists® (ASA), appreciates the opportunity to comment on the above-captioned Proposed Rule. Medicare is an essential program that currently provides health care benefits to 58 million Americans. Medicare Advantage (MA) is a growing means of coverage for this population with an estimated 26 million Medicare beneficiaries enrolled in an MA plan in 2021.[1] ASA is committed to working with the Centers for Medicare and Medicaid Services (CMS) to promote policies that support high quality care in a fiscally sustainable manner in the Medicare fee-for-service and MA environments. We are pleased to work with the agency to create a health care system that reduces administrative burden on practicing physicians; supports the provision of high-quality, cost-effective care; and is forward-thinking in the development of innovative solutions to overcome the challenges facing clinicians, patients, and the Medicare system overall. As the medical specialty representing the recognized leaders in patient safety and quality, ASA welcomes the opportunity to work with you to ensure high-quality and high-value care for our patients with Medicare.

Generally, health insurers have broad latitude to define the breadth and number of physicians and other clinicians in their networks. They may do this to coordinate care or control costs. The federal government and many states have established network adequacy standards to ensure that health plans have minimum numbers and ranges of physicians to deliver the benefits promised under the terms of the contract. ASA provides comments on the proposal in this rule to amend MA network adequacy rules by requiring compliance of network adequacy standards during the application process.

[1] Freed, M., Biniek, J. F., Damico, A., & Neuman, T. (2021, June 21). *Medicare Advantage in 2021: Enrollment Update and Key Trends*. Kaiser Family Foundation. Retrieved February 22, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

MA Network Adequacy Rules

In this rule CMS proposes to amend MA network adequacy rules by requiring plans that are applying for new or expanded service areas to demonstrate they meet MA network adequacy standards as part of the application process. Plans will receive a 10-percentage point credit toward meeting standards but once the contract is operational, the credit no longer applies, and the plan would need to demonstrate full compliance. The additional support of the 10-percentage point credit is offered because the agency believes it might be difficult in some instances to have a network fully in place a year ahead of the contract effective date. As required by statute, Medicare regulations (§ 422.116) require MA plans to meet network adequacy criteria related to minimum number of providers and facilities, and maximum travel time and distance.

ASA supports the proposal to require plans to demonstrate that they meet network adequacy standards as part of the application process. We urge the agency to finalize this proposal. We believe this proposal will provide greater oversight. Additionally, requiring a network largely in place ahead of time, will reduce the need for last minute changes that could impact final bid pricing data or compromise patient access to care.

While we support this proposal, ASA also urges CMS to implement additional policies to ensure compliance around these critical criteria.

Physician Anesthesiologists and Pain Medicine Specialists

42 CFR §422.116 details the network adequacy requirements for MA plans. Provider specialty types are listed under §422.116(b)(1). Neither anesthesiology nor pain medicine are included in this list of provider specialty types. §422.116(b)(2) list facility specialty types. As a facility-based specialty, anesthesiology could be assumed to be subsumed under one of the facility specialty types such as “acute inpatient hospital” that are included in this list.

ASA is concerned that neither physician anesthesiologists nor pain medicine specialists are specifically identified as one of the provider specialties specifically identified in regulations to which the network adequacy criteria apply. While we believe that the requirements for acute inpatient hospitals, outpatient facilities and ambulatory surgical centers are helpful; because plans are not specifically required to maintain a minimum number of anesthesiologists, the agency should monitor plans to ensure that they have enough physician anesthesiologists and pain medicine specialists in their network to meet the needs of Medicare beneficiaries. Physician anesthesiologists specialize in anesthesia care, pain management, and critical care medicine. They play an important and unique role in the care of patients that cannot be replaced by physicians not board certified in anesthesiology. Physician anesthesiologists evaluate, monitor, and supervise patient care before, during, and after surgery, delivering anesthesia, leading the anesthesia care team, and ensuring optimal patient safety. Anesthesiologists play a vital role in assessing a patient's medical readiness for surgery. They are unique in their advanced knowledge of both the medical illnesses a patient undergoing surgery may suffer, as well as the effects on the body of the specific operation to be performed.

Presumably, when plans contract with hospitals or surgical centers to provide surgical services, they likewise are ensuring that those facilities have a sufficient number of anesthesiologists on staff and contracted to meet surgical service expectations. However, physician anesthesiologists do much more than support surgical procedures. They also address clinical needs outside of the operating room environment (*e.g.* interventional radiology, interventional cardiology and other procedures requiring non-operating room anesthetic services (NORA)).

In addition to the role physician anesthesiologists play in surgical care, critical care and NORA services; physician anesthesiologists are also leaders in the specialty of pain management. Physician anesthesiologists board certified in pain medicine treat a wide spectrum of disorders including acute pain, chronic pain and cancer pain and sometimes a combination of these.

Because of the unique role of the specialty, not having an adequate number of physician anesthesiologists and pain medicine specialists can compromise access to care across a wide range of surgical and other critical services.

Adding anesthesiologists and pain medicine specialists to (§ 422.116 (b)(1) Provider Specialty Types)

ASA urges CMS to add anesthesiology and pain medicine to the list of provider specialty types under § 422.116 (b)(1). *While in the past it may have been adequate to assume that the specialty was subsumed under the list of facility specialty types, recent trends indicate that this may no longer be sufficient. ASA believes recent actions by plans indicate a need for them to be specifically listed as a specialty under (§ 422.116 (b)(1)).*

We are seeing a disturbing trend of plans not contracting with anesthesiologists and believe this provides evidence that there should be more robust requirements around having an adequate number of anesthesiologists in a network. Plans may be doing this because of the recent implementation of federal Surprise Billing requirements which apply to nearly all private health plans. Many plans now find it advantageous to not contract with anesthesiologists with a practical effect that there are no anesthesiologists in their networks. Our role as pain management specialists provides an additional rationale for specifically listing the specialty under provider specialty types in § 422.116 (b)(1).

ASA recommends that CMS add anesthesiology and pain medicine to the list of provider specialty types under (§ 422.116 (b)(1).

Transparency

ASA believes that to ensure that patients have access to in-network physicians and that there is fair and equitable treatment of physicians and other clinicians by MA plans, greater transparency is needed in how networks are established.

ASA recommends that the criteria used by plans to evaluate the inclusion of a physician or practice group in a network should be submitted to CMS and made publicly available.

Ongoing Monitoring

Appropriate network adequacy provides a measurement of a plan's capacity to provide sufficient access to contracted physicians and other healthcare providers in each physician specialty and geographic area. Narrow networks are a significant cause of unanticipated out of network care. Medicare beneficiaries participating in MA plans should not be faced with narrow networks which may result in reduced access to care or the provision of more costly out-of-network care. ASA urges CMS to provide robust oversight over these plans to ensure that patients are not caught in the middle of such situations which are inherently unfair to patients and nor should CMS be rewarding plans who have established inappropriately narrow networks.

ASA recommends that CMS should require plans to submit data no less frequently than on an annual basis to ensure that they continue to meet the network adequacy standards throughout the year.

We would be very glad to follow up with you as necessary on any issues for which you need additional information or would like further discussion. Please contact Sharon Merrick, MS, CCS-P, ASA Director of Payment and Practice Management at (202) 289-2222.

Sincerely,

Randall M. Clark, MD, FASA
President