American Association of
NURSE ANESTHESIOLOGY

June 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1771-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1771-P – Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plan; and Changes to Hospital and Critical Access Hospital Conditions of Participation Proposed Rule (87 Fed.Reg. 28108 May 10, 2022)

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this proposed rule; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plan; and Changes to Hospital and Critical Access Hospital Conditions of Participation (87 Fed.Reg. 28108, May 10, 2022). The AANA makes the following comments and requests of CMS:

MEDICARE+CHOICE NURSING AND ALLIED HEALTH EDUCATION PROGRAMS

- Clarify that Calculation of the Direct GME MA Percent Reduction is Separate from the Allocation of Funds for the NAH Pass-Through Payment

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

- Support Proposed Severe Obstetric Complications eCQM
- In Considering Additional Sources for Maternal Health Designation, Ensure Availability of Obstetrical Anesthesia Services Provided by CRNAs Who Are Working at the Top of Scope, Education, and Licensure

ADDITIONAL ACTIVITIES TO ADVANCE MATERNAL HEALTH EQUITY—REQUEST FOR INFORMATION

- Policies Implemented Through This RFI Should Be Evidence-Based
- Policies Should Promote Full Scope of Practice and Remove Barriers to Access to Care in Rural Areas
- Consider AANA Resources on Obstetrical Anesthesia as Part of Best Practices

REQUEST FOR PUBLIC COMMENTS ON IPPS AND OPPS PAYMENT ADJUSTMENTS FOR WHOLLY DOMESTICALLY MADE NIOSH-APPROVED SURGICAL N95 RESPIRATORS

- Provide Priority PPE Funding to Areas Where Providers Would be in the Highest Risk

Background of the AANA and CRNAs

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 and are included among the nation's most trusted professions according to Gallup[1]. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA

[1] Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx.

services are 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 also 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 many necessary procedures.

CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient 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 and recovery. CRNAs also provide acute, chronic, and interventional pain management services. 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. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. 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.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *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.[2] An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[3] Researchers studying anesthesia

[2] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[3] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs.* 2010; 29: 1469-1475. http://content.healthaffairs.org/content/29/8/1469.full.pdf

safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.[4] Most recently, a study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[5]

The importance of CRNA services in rural areas was highlighted in a recent 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. Allowing them to participate in rural emergency hospitals will increase needed access to care for patients who live in these areas.

[4] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[5] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[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.

MEDICARE+CHOICE NURSING AND ALLIED HEALTH EDUCATION PROGRAMS

AANA Request: Clarify that Calculation of the Direct GME MA Percent Reduction is Separate from the Allocation of Funds for the NAH Pass-Through Payment

The AANA appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts in support of the nursing and allied health (NAH) education programs. As workforce shortages persist and the pipeline of future nurses is threatened, it is vital that these essential avenues are kept intact. This is a significant issue with the healthcare workforce, and amongst the nursing workforce in particular. A recent article in Health Affairs entitled *A Worrisome Drop in the Number of Young Nurses* highlights the issues that we are facing with the nursing workforce.[8] According to the article, "Now, two years into the COVID-19 pandemic, the supply of RNs is under threat again. Using monthly data from the Current Population Survey, our recently published analyses in Health Affairs showed that growth in the RN workforce plateaued during the first 15 months of the pandemic. Although it is difficult to disentangle the contributing factors, these likely include early retirements, pandemic burnout and frustration, interrupted work patterns from family needs such as childcare and elder care, COVID-19 infection and related staffing shortages, and other disruptions throughout health care delivery organizations. Extending that analysis through the end of 2021 furthers our concern. New data here, covering the entirety of 2021, show the total supply of RNs decreased by more than 100,000 in one year—a far greater drop than ever observed over the past four decades." This underscores the urgency for which we need to be working to increase the pipeline of nurses. For this reason, we request clarification that the calculation of the direct graduate medical education (GME) Medicare Advantage (MA) percent reduction is separate from the allocation of funds used for the NAH pass-through payment.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

AANA Request: Support Proposed Severe Obstetric Complications eCQM

[8] See: https://www.healthaffairs.org/do/10.1377/forefront.20220412.311784/

The AANA supports inclusion and tracking of the Severe Obstetrics Complications eCQM measure in the Hospital Inpatient Quality Reporting (IQR) Program. In particular, the AANA also supports the CMS's efforts in improving maternal health and stands ready to support the agency. The numerator for this eCQM will include diagnosis codes that capture anesthesia complications by type. These are already used in current anesthesia quality measures, so the data should be readily available.

AANA Request: In Considering Additional Sources for Maternal Health Designation, Ensure Availability of Obstetrical Anesthesia Services Provided by CRNAs Who Are Working at the Top of Scope, Education, and Licensure

The AANA supports meaningful representation of the maternal health designation for hospitals. As CRNAs 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, we therefore recommend that any maternal care designation include access to CRNA obstetrical anesthesia services across all levels and promotion of CRNAs working at the top of their scope, education and licensure. This information will ensure that such hospital designation more completely captures the quality and safety of maternity care furnished by hospitals.

ADDITIONAL ACTIVITIES TO ADVANCE MATERNAL HEALTH EQUITY—REQUEST FOR INFORMATION

AANA Comment: Policies Implemented Through This RFI Should Be Evidence-Based

The AANA appreciates CMS's efforts to address the U.S. maternal health crisis through policies and programs and in offering this request for information. CRNAs provide pain control via neuraxial techniques, such as epidurals and spinals, to help facilitate labor and delivery. The neuraxial technique is utilized to provide adequate pain relief and/or sensory blockade while preserving motor function, typically achieved by administering a combination of local

anesthetics and opioids, which allows for lower doses of each agent and mitigates adverse side effects and shortens latency. In addition, CRNAs play a critical role in the prevention of non-anesthesia-related maternal deaths, such as those caused by hemorrhage, hemodynamic instability, critical illness, and sepsis. The AANA was involved in the American College of Obstetricians and Gynecologists (ACOG) Council on Patient Safety in Women's Healthcare, and helped in the development of evidence-based safety bundles for maternal care. These bundles included the topics of obstetric hemorrhage, hypertension in pregnancy, perinatal depressional and anxiety, reduction of primary cesarean birth, support after a severe maternal event, and venous thromboembolism.[9]

The AANA cautions CMS on adopting any policies that use the 2019 Levels of Maternal Care (LoMC) published by the ACOG, which are not uniformly based in evidence. The LoMC may have serious repercussions for maternal patients across the country, but especially in rural and other medically underserved areas; for the ob-gyns and CRNAs who provide maternal patient care; and for the facilities that serve this patient population. We request that CMS ensures that future maternal health policies implemented are evidence-based.

The revised consensus statement for Level II requirements in the LoMC Consensus Statement state that an anesthesiologist be "readily available 24 hours a day, 7 days a week, for consultation and assistance, and able to be physically present onsite within a time frame that incorporates maternal and fetal/neonatal risks and benefits with the provision of care. Further defining this time frame should be individualized by facilities and regions, with input from their obstetric care providers."

The AANA is unaware of any evidence that supports the requirement for an anesthesiologist to be "available 24 hours a day, 7 days a week" or that shows this requirement will improve maternal and child outcomes. The AANA supports the adoption of evidence interventions that improve access to care and the quality of care given to patients. The adoption of this statement achieves neither.

[9] See: www.safehealthcareforeverywoman.org.

The AANA believes that including an anesthesiologist preference in any consensus statement has the potential of negative consequences associated with adoption, especially in light of critical workforce shortages. We are concerned that anesthesiologists will in turn market their skills as superior to CRNAs, pointing to support and confirmation from ACOG's LoMCs. ACOG indicates the extensive benefits of complying with the LoMCs. If facilities cannot meet these requirements, they, like CRNAs, may risk loss of advantages in marketing, contracting, and reimbursement, may violate state law that incorporates these requirements, and may suffer other unnecessary harms. CRNAs will suffer additional negative effects as small facilities that cannot afford extra staff and the cost of an anesthesiologist in addition to the CRNA are incentivized to replace CRNAs with anesthesiologists to meet the anesthesiologist readily available requirements.

Contrary to the ACOG consensus statement is the successful track record of CRNAs, who have been extensively studied and found to have excellent quality of care outcomes that are equivalent to anesthesiologists. As mentioned previously, gold-standard studies show that CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery and there are no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[10] We therefore request that CMS implement policies through this RFI that are evidence-based.

AANA Request: Policies Should Promote Full Scope of Practice and Remove Barriers to Access to Care in Rural Areas

The AANA recommends that CMS remove barriers to patients' access to care by ensuring that all APRNs, including CRNAs, practice to their full professional education, skills, and scope of practice. In particular, CRNAs play an essential role in ensuring that rural America has access to critical anesthesia services, including critical obstetrical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures. One of the concerns is availability of clinicians in hospital to

[10] Paul F. Hogan et. al Op Cit and B. Dulisse and J. Cromwell Op Cit.

respond to emergency maternal events, such as maternal hemorrhage and hypertensive crisis. If obstetric providers and anesthesia providers are not in the hospital, they cannot address a maternal emergency timely. Maternal hemorrhage needs to be addressed immediately; the uterus receives 700-900 mL of blood/minute, the total volume of blood is 6 liters, thus is a woman is bleeding from the uterus after delivery she can lose total blood volume in 10 minutes, yet the requirement is for obstetric providers and anesthesia providers to be present in 30 minutes.

The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography, insurance type, and the distribution of anesthesia provider type.[11] 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 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.

This policy recommendation also corresponds with a recommendation from the National Academy of Medicine's (NAM) report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs, including CRNAs.[12] The NAM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[13]

As part of this policy recommendation, an existing policy barrier we recommend that CMS permanently remove is unnecessary physician supervision requirements as part of the Medicare

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

[12] National Academy of Medicine. The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011); p. 69.

[13] NAM op. cit. p. 7-8.

Conditions of Participation (CoPs).[14] Permanently removing unnecessary supervision requirements is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice.[15]

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[16] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 22 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[17] Previously stated, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[18]

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. In 2015, self-employed CRNAs paid 33 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2015, the reduction in CRNA liability premiums is an astounding 65 percent less than approximately 25 years ago according to Anesthesia Insurance Services, Inc. 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

[14] *See* 42 CFR §§ 482.52, 485.639, 416.42.

[15] 42 CFR §410.69(b), 77 Fed. Reg. 68892, November 16, 2012.

[16] Dulisse, op. cit.

[17] Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010.

[18] Negrusa B et al. op. cit.

without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[19]

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by an anesthesiologist who is immediately available if needed, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a CoP. The AANA receives reports from the field that anesthesiologists suggest erroneously that supervision is some type of quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision CoP. When this ideology is established, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard.[20] But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

According to a nationwide survey of anesthesiology group subsidies,[21] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

[19] Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169.

[20] 63 FR 58813, November 2, 1998.

[21] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.

As independently licensed professionals, CRNAs are responsible and accountable for judgments made and actions taken in his or her professional practice.[22] The scope of practice of the CRNA addresses the responsibilities associated with anesthesia practice and pain management that are performed by the nurse anesthetist as a member of inter-professional teams. The same principles are used to determine liability for surgeons for negligence of anesthesiologists or nurse anesthetists. The laws' tradition of basing surgeon liability on control predates the discovery of anesthesia and continues today regardless of whether the surgeon is working with an anesthesiologist or a nurse anesthetist. [23]

There is strong evidence in the literature that anesthesiologist supervision fails to comply with federal requirements, either the Part A conditions of participation or Part B conditions for coverage. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*,[24] the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. This is consistent with over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists *ASA Relative Value Guide 2013* suggests loosening further the requirements that anesthesiologists must meet to be "immediately available," stating that it is "impossible to define a specific time or distance for physical proximity." This *ASA Relative Value Guide* definition marginalizes any relationship that the "supervisor" has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions, which require

[22] American Association of Nurse Anesthetists. Code of Ethics for the Certified Registered Nurse Anesthetist. Adopted 1986, Revised 2018. See: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/code-of-ethics-for-the-crna.pdf?sfvrsn=d70049b1_2

[23] Blumenreich, G. Another article on the surgeon's liability for anesthesia negligence. *AANA Journal*. April 2007.

[24] Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. Anesth. 2012;116(3): 683-691.

anesthesiologists claiming to fulfill the role of "supervising" CRNA services be physically present in the operating room or suite.

If a regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, we recommend that CMS remove unnecessary supervision requirements in the Medicare CoPs.

AANA Comment: Consider AANA Resources on Obstetrical Anesthesia as Part of Best Practices

The AANA has several resources with respect to obstetrical anesthesia that the agency may want to take into account with respect to best practices. AANA developed guidelines for the management of the obstetrical patient, which were recently updated *Analgesia and Anesthesia for the Obstetric Patient Practice Guidelines Analgesia and Anesthesia for the Obstetric Patient Practice Guidelines.*[25] These guidelines promote safe and effective anesthesia care for obstetrical patients and provide guidance for anesthesia professionals and healthcare institutions. As stated in the guidelines, ideal medications for labor analgesia provide effective analgesia with minimal motor blockade, minimal risk of maternal and fetal toxicity, and negligible effect on uterine activity and uteroplacental perfusion. Other important aspects of these guidelines that could be part of best practices include:

- CRNAs conduct a pre-anesthesia assessment and evaluation. CRNAs complete an assessment and evaluation criteria regarding general health, allergies, medication history, preexisting conditions, and anesthesia history in order to develop a patient-specific plan for analgesia and anesthesia. Patients whose obstetric anesthesia care may be challenging or are known to be at risk of significant morbidity should be evaluated for analgesia and anesthesia prior to labor in collaboration with the interprofessional team.

[25] See: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/analgesia-and-anesthesia-for-the-obstetric-patient.pdf?sfvrsn=be7446b1_10

- The anesthesia professional, in partnership with the interprofessional healthcare team, develops the plan of anesthesia care with the patient as an engaged, informed and active decision-maker. The informed consent process provides an opportunity for the anesthesia professional and the patient to share information and explore patient needs, preferences, previous experiences, and concerns to develop the plan for anesthesia care.
- It is ideal to discuss options for analgesia and anesthesia as early as possible. When obtaining informed consent during active labor, time the discussion to occur between contractions to allow the patient to best participate in the discussion. With the patient's consent, conduct discussions when the patient's family or other support persons are present in compliance with the patient's wishes and applicable healthcare privacy laws.
- Choice of pain relief should be based on patient condition, provider skill set and the resources available at the practice setting. Analgesia and anesthesia considerations are unique for each patient during the three stages of labor, beginning prior to regular uterine contractions, through vaginal or surgical delivery, and continuing after delivery to address any acute pain management needs. Analgesia is individualized to address the stage of labor, maternal discomfort and fetal status.[26] A multimodal plan for labor and, when necessary, surgical analgesia, limits the use of opioids through a patient-specific plan of care that integrates non- pharmacologic, parental opioid, non-opioid, neuraxial and surgical field block. Refer to facility policy for guidance regarding family member presence during analgesia and anesthesia procedures.

In addition to these guidelines, the AANA provides ongoing continuing education opportunities that are essential for maternal health. Such activities include lectures and crisis simulation training for maternal hemorrhage offered during AANA Annual Congress and an annual clinical skills workshop specifically for obstetric anesthesia providers at the AANA Spinal/Epidural Obstetric Essentials Workshop.

[26] See: Committee on Practice B-O. Practice Bulletin No. 177: Obstetric Analgesia and Anesthesia. Obstet. Gynecol. Apr 2017;129(4):e73-e89 and Orejuela FJ, Garcia T, Green C, Kilpatrick C, Guzman S, Blackwell S. Exploring factors influencing patient request for epidural analgesia on admission to labor and delivery in a predominantly Latino population. J. Immigr. Minor. Health. Apr 2012;14(2):287-291.

REQUEST FOR PUBLIC COMMENTS ON IPPS AND OPPS PAYMENT ADJUSTMENTS FOR WHOLLY DOMESTICALLY MADE NIOSH-APPROVED SURGICAL N95 RESPIRATORS

AANA Request: Provide Priority PPE Funding to Areas Where Providers Would be in the Highest Risk

The AANA supports the need to provide appropriate protection for healthcare providers and ensure that facilities have the resources to be able to secure required equipment and PPE. We recommend priority funding to areas where providers would be in the highest risk. During this pandemic, CRNAs have played a role providing critical, lifesaving care to patients 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. Appropriate personal protective equipment (PPE) to treat COVID-19 patients includes fitted N95 masks; powered air purifying respirators (PAPRs);[27] and may include other NIOSH or CDC approved respirators.[28] Personnel participating in aerosol-generating procedures also wear eye protection (goggles or a disposable face shield that covers the front and sides of the face), a gown, and gloves, in addition to airway protection with N95 masks or PAPRs.

We believe infectious disease payment should account for the equipment and resources used directly for care situations that are directly related to the PHE. Some examples include: 1) there is a surge of COVID-19 patients requiring anesthesia care, and also necessitating the use of all the required PPE to protect providers, which would not have been needed without the surge in the number of infected patients; 2) the anesthesia provider or department has decided to use PPE and protective devices for all patients, infected or not infected, due to the risk of COVID-19 infection, regardless of the patients' COVID-19 infection status, because of the pandemic

[27] PAPRs should be used by individuals who are not N95 fit-tested, have facial hair, or fail N95 fit-testing.

[28] AANA, ASA, APSF and AAAA Issue Joint Statement on Use of Personal Protective Equipment During COVID-19 Pandemic, see: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/update-the-use-of-personal-protective-equipment-by-anesthesia-professionals-during-the-covid-19-pandemic.pdf?sfvrsn=201caffe_6.

conditions. Before the pandemic, this additional PPE and/or protective equipment would not have been used for all patients.

CRNAs involved in care during the pandemic may either be employed by facilities or work in independent practice, which typically involves providing care under a contractual agreement with a health care facility. Employers typically bear the additional costs of equipment and resources for CRNAs who are employed by these facilities, including additional employee protections as mandated by CDC and OSHA during the pandemic. The additional costs of providing care for CRNAs who work in independent practice will depend on the contractual provisions between the provider and health care facilities using their services. To a greater or lesser degree, depending upon the contract conditions, either the CRNA and or the facility will be responsible for the costs of: gowns, PAPRs, eye protective goggles, and N95 masks, and any additional anesthesia equipment such as clear plastic shields around the patient's head, and any other protective items that would not have been used in a typical case prior to pandemic conditions.

Furthermore, there may be additional costs to clinicians of an increase in non-COVID-19 infections during the pandemic. There is a concern that hospital acquired infection rates have been going up as there has been potential rebound in the numbers of non-COVID-19 infections during the pandemic.[29] COVID-19 patients are more at risk for CLABSIs and CAUTIs than non-COVID-19 patients.[30]

We thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202.484.8400, rkohl@aanadc.com.

[29] McMullen KM, Smith BA, Rebmann T. Impact of SARS-CoV-2 on hospital-acquired infection rates in the United States: Predictions and early results. Am J Infect Control. 2020;48(11):1409-1411.

[30] See: https://nurseanesthesiology.aana.com/impacts-on-hospital-acquired-infection-rates-due-to-the-sars-cov-2-pandemic.

Sincerely,

Dina Velocci, DNP, CRNA, APRN
AANA President

cc: Ralph Kohl, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy