AANA
American Association of
NURSE ANESTHESIOLOGY

June 5, 2024

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1808-P
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1808-P –Medicare and Medicaid Programs and Children's Health Insurance Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 20245 Rates; Quality Programs Requirements; and Other Policy Changes (89 Fed.Reg. 35934, May 2, 2024)

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this Propose Rule: Medicare and Medicaid Programs and Children's Health Insurance Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 20245 Rates; Quality Programs Requirements; and Other Policy Changes (89 Fed.Reg. 35934, May 2, 2024). The AANA makes the following comments and requests:

- Clarify How Anesthesia is Treated Under TEAM Model
- Pilot Test Collections Metrics for Waste Anesthetic Gases
- CoPs for Obstetrical Services Should Recognize Healthcare Providers Operating at the Top of their Scope and Should Be Evidence-Based

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists. AANA membership includes more than 61,000 CRNAs

and SRNAs, representing about 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. For further information, see: https://www.aana.com/about-us.

AANA Request: Clarify How Anesthesia is Treated Under TEAM Model

While AANA appreciates that the Centers for Medicare & Medicaid Services (CMS) is developing models that help with the coordination of care during and after certain surgical procedures, we would appreciate a bit more clarification on how anesthesia and hospital-based anesthesia providers fit into the Transforming Episode Accountability Model (TEAM). This is particularly important to help prepare CRNAs to participate in the program. Under the requirements for the MIPS program, hospital-based CRNAs are eligible for exclusion for reporting on the Promoting Interoperability category, and most services they provide do not trigger Cost measures, so financial incentives under this model would be limited for them. Also, since TEAM is a hospital-based model and the model could qualify as a MIPS APM, it would be important to know if CMS anticipates developing associated measures for clinicians like CRNAs who bill under Part B and whether those measures would be applicable to anesthesia.

AANA Request: Pilot Test Collection Metrics for Waste Anesthetic Gases

AANA appreciates that CMS is focusing on waste anesthetic gases (WAG) as part of its Decarbonization and Resilience Initiative. In addition to environmental effects being a concern, exposure to WAGs can lead to serious adverse health effects, including birth defects, cancer, liver and kidney disease. AANA recognizes the important role that CRNAs can play in being part of the solution to reducing WAGs. Because of this, AANA recently developed policy consideration outlining steps to be taken to minimize WAG for facilities that utilize inhaled anesthetic agents.[1]

While AANA agrees that anesthetic gas metrics can be appropriate to collect, we recommend that CMS pilot test collection metrics before implementing on a large scale to ensure that data elements can be captured uniformly. As CMS is considering capturing anesthetic hours as part of the reporting process, we caution that the use of anesthetic hours can be challenging given documentation of anesthesia time for billing. For instance, anesthesia start times can vary based on the circumstance, such as different start times with the placement of catheter or in an emergency. Also, since base units are documented in 15-minute increments and not hours, this requires aggregation in order to calculate anesthetic hours, which could add to clinician administrative burden.

[1] American Association of Nurse Anesthesiology, "Management of Waste Anesthetic Gases: Policy Considerations, April 2024, available at: https://issuu.com/aanapublishing/docs/2_-_management_of_waste_anesthetic_8c0745b2cdeda9?fr=xKAE9_-Dctg.

AANA Request: CoPs for Obstetrical Services Should Recognize Healthcare Providers Operating at the Top of their Scope and Should Be Evidence-Based

AANA appreciates CMS's efforts to improve maternal health care and improve access to care. In the developing of Condition of Participations (CoPs) for obstetrical services for hospitals, critical access hospitals, and for rural emergency hospitals, we strongly urge CMS to recognize healthcare professionals operating at the top of their scope with respect to the delivery of obstetrical anesthesia and to not create any additional barriers to care by imposing standards that are not based in evidence. 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.[2]

AANA cautions CMS on adopting any standards 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 any CoPs that are 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.

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

[2] See: www.safehealthcareforeverywoman.org.

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. 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.[3]

Thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding these matters, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,

Dru Riddle, PhD, DNP, CRNA, FAAN
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrid Lusis, AANA Chief Advocacy Officer
Romy Gelb-Zimmer, MPP, AANA Director of Regulatory Affairs

[3] See Paul F. Hogan et. al Op Cit and B. Dulisse and J. Cromwell Op Cit.and Needleman J, Minnick AF. Anesthesia provider model, hospital resources, and maternal outcomes. Health Serv Res. 2009;44(2 Pt 1):464-482. doi:10.1111/j.1475-6773.2008.00919.x