Statement for the Record
American Association of Nurse Practitioners
For the United States House Committee on Energy and Commerce
Subcommittee on Health
"Enhancing Public Health: Legislation to Protect Children and Families"
October 20, 2021

On behalf of the more than 325,000 nurse practitioners (NPs) across the nation, the American Association of Nurse Practitioners (AANP) appreciates the opportunity to provide the following statement for the record to the United States House Committee on Energy and Commerce (the Committee) and the Subcommittee on Health. We commend committee Chairman Pallone and Ranking Member McMorris Rodgers, subcommittee Chair Eshoo and Ranking Member Guthrie and the members of the Committee and Subcommittee, particularly bill sponsor Rep. Blunt Rochester, for including H.R. 1956 the "*Increasing Access to Quality Cardiac Rehabilitation Care Act of 2021*" in the discussion during this hearing**.** This legislation has broad support within the health care community and would expediate the *Bipartisan Budget Act of 2018*'s (BBA's) **(**Pub. L. 115–123) authorization for NPs (and physician assistants (PAs) and clinical nurse specialists (CNSs)) to supervise cardiac rehabilitation and pulmonary rehabilitation from 2024 to 2022 and would also authorize NPs (and PAs and CNSs) to order cardiac and pulmonary rehabilitation services beginning in 2022. While cardiac and pulmonary rehabilitation are lifesaving services, they are severely underutilized. This legislation will increase patient access to these critical programs, particularly in rural and underserved communities, as well as help to alleviate the health care disparities that were exacerbated by the COVID-19 pandemic.

Background on Nurse Practitioners

As you are aware, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs practice in nearly every health care setting including clinics, hospitals, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs), nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.), have full practice authority in 24 states, D.C., and 2 territories and perform more than one billion patient visits annually.

As of 2019, there were more than 163,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[1] Approximately 40% of Medicare patients receive billable services from a nurse practitioner[2] and approximately 80% of NPs are seeing Medicare and Medicaid patients.[3] NPs have a particularly large impact on primary care as approximately 70% of all NP graduates deliver primary care[4] and NPs comprise approximately one quarter of the primary care workforce, with that percentage growing annually.[5]

They provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status. Further, a recent study found that NPs "are significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[6] As such, NPs understand the barriers to care that face vulnerable populations daily.[7,8,9] NPs are the second largest provider group in the National Health Services Corps[10] and the number of NPs practicing in community health centers has grown significantly over the past decade.[11] Rural communities are disproportionately impacted by health care inequities, which are exacerbated when communities experience rural hospital closures. However, when rural hospitals do close, APRNs, including NPs, continue to provide care in those communities. According to the Government Accountability Office (GAO), "from 2012 to 2017, the availability of all physicians declined more among counties with closures (16.2 percent) compared to counties without closures (1.3 percent)" whereas "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[12]

[1] https://www.cms.gov/files/document/2019cpsmdcrproviders6.pdf
[2] https://www.cms.gov/files/document/2019cpsmdcrphyssupp6.pdf
[3] https://www.aanp.org/about/all-about-nps/np-fact-sheet.
[4] https://www.aanp.org/about/all-about-nps/np-fact-sheet.
[5] Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners, Hilary Barnes, Michael R. Richards, Matthew D. McHugh, and Grant Martsolf, Health Affairs 2018 37:6, 908-914.
[6] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[7] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.
[8] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.
[9] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070
[10] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf
[11] https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf
[12] https://www.gao.gov/assets/gao-21-93.pdf.

Decades of evidence demonstrate the high-quality, cost-effective care that NPs provide to their patients, including patients with cardiovascular and pulmonary disease who would qualify for cardiac and pulmonary rehabilitation.[13,14] NPs are particularly skilled at these types of clinical interventions and help patients manage their conditions due to their whole-person centered approach to health care delivery. NPs were early adopters of the Patient Centered Medical Home model which successfully incorporates care coordination, care planning and consistent patient outreach, and nurse-managed health clinics are vital sources of care to patients with acute and chronic conditions in rural and underserved communities. Authorizing NPs to order and supervise cardiac and pulmonary rehabilitation will reduce barriers to care for patients in need of these services and improve the ability of NPs to ensure their patients receive this medically necessary care in a timely fashion.

Importance of Increasing Access to Cardiac and Pulmonary Rehabilitation

Cardiac rehabilitation and pulmonary rehabilitation are programs designed to improve a patient's physical, psychological, and social functioning after a qualifying diagnosis or procedure, such as a heart attack or coronary artery bypass surgery or after a diagnosis of chronic obstructive pulmonary disease (COPD). Heart disease is the leading cause of death each year, killing over 659,000 Americans, or approximately one in four deaths, and COPD is the fourth leading cause of death.[15,16] Yet, while studies show that these programs can reduce hospitalizations, decrease heart attack recurrence, increase adherence to preventive medication, improve overall health and reduce the need for costly care,[17,18] less than 25 percent of qualifying patients receive cardiac rehabilitation and only three percent of Medicare patients with COPD receive pulmonary rehabilitation.[19,20] Participation rates are even lower for female and minority patients and those who live outside metropolitan areas or in lower income urban areas. For instance, one study found that female, black, Hispanic, and Asian patients were 12%, 20%, 36% and 50% less likely to be referred for cardiac rehabilitation, respectively.[21] Research also indicates that cardiac rehabilitation is associated with lower all-cause mortality rates in patients with diabetes; however, patients with diabetes have lower participation rates in cardiac rehabilitation than the non-diabetes population.[22]

[13] https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice
[14] https://www.aanp.org/advocacy/advocacy-resource/position-statements/nurse-practitioner-cost-effectiveness.
[15] https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC
[16] https://www.cdc.gov/heartdisease/facts.hthttps://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OCm
[17] https://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_493752.pdf.
[18] https://takeheart.ahrq.gov/case-cardiac-rehabilitation/benefits
[19] https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.119.005902
[20] https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC
[21] Li, S., Fonarow, G.C., Mukamal, K., Xu, H., Matsouaka, R.A., Devore, A.D., & Bhatt, D.L. (2018). Sex and racial disparities in cardiac rehabilitation referral at hospital discharge and gaps in long-term mortality. Journal of the American Heart Association. 7(8). Doi: 10.1161/JAHA.117.
[22] https://www.ahajournals.org/doi/10.1161/JAHA.117.006404.

In an effort to increase Medicare patients' access to cardiac and pulmonary rehabilitation, Congress passed the BBA in 2018, which authorized NPs to supervise cardiac and pulmonary rehabilitation beginning in 2024. However, further modernization of Medicare is still needed to expedite the BBA authorization of NP supervision of these programs and to authorize NPs to order these services for their patients. Removal of these outdated barriers will allow Medicare patients to have timely access to these critical programs. While an NP may be the primary care provider for a patient and be most familiar with the patient's health care needs, under current law, the NP must refer the patient to a physician to order these services, and a physician must also supervise these services until 2024 when the BBA authorization takes effect for NPs to supervise cardiac and pulmonary rehab. The Medicare program generally authorizes NPs to perform, order and supervise any Medicare-covered services in accordance with state law, and the barriers regarding cardiac and pulmonary rehabilitation are outliers in this respect.

The Centers for Medicare and Medicaid Services (CMS) has also noted that cardiac and pulmonary rehabilitation improve patient outcomes, but the services are underutilized.[23] The Center for Medicare and Medicaid Innovation (CMMI) recognized that the physician order and supervision requirements were reducing access to cardiac rehabilitation and would have authorized nurse practitioners to provide these services in the proposed Cardiac Rehabilitation Incentive Payment model planned for 2017.[24] While that model did not come into effect for other reasons, the reduction of those regulatory barriers was widely supported among stakeholders. CMMI is currently considering similar waivers for cardiac and pulmonary rehabilitation in the Direct Contracting models.[25] Most recently in the 2022 Medicare Physician Fee Schedule proposed rule, CMS recognized the importance of pulmonary rehabilitation in the treatment of post-COVID symptoms by proposing to expand pulmonary rehabilitation coverage to include patients who were hospitalized for COVID-19 and experienced persistent symptoms, including pulmonary dysfunction.[26] While it is important for patients with these newly eligible conditions to receive these services, it is critical that Congress acts to remove the barriers on NPs for pulmonary rehabilitation so that the already limited access to these programs is not exacerbated.

At the state level, most states do not regulate cardiac and pulmonary rehabilitation with the same degree of specificity as within the Medicare program. The states that do regulate cardiac and pulmonary rehabilitation in more detail tend to mirror current federal policy. However, as we have seen with the changes pursuant to the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) which authorized NPs, PAs and CNSs to order Medicare and Medicaid home health services, once Medicare updates its policies, most states will quickly follow suit with corresponding state regulations. Within one year of CMS issuing final regulations to authorize NPs and PAs to order home health services, approximately 35 states took corresponding actions to

[23] 82 FR 50784, 50800.
[24] https://innovation.cms.gov/files/fact-sheet/cr-providertech-fs.pdf. (page 5)
[25] https://innovation.cms.gov/media/document/geo-dc-rfa (page 32); https://innovation.cms.gov/media/document/gpdc-model-general-faqs (page 17).
[26] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule

update or waive inconsistent state regulations or statutes. Additionally, it is important to note that ordering and supervising cardiac and pulmonary rehabilitation is within the scope of practice for NPs.

NPs are clinically trained to provide high-quality and timely care to patients in need of cardiac and pulmonary rehabilitation. NPs also routinely serve as frontline providers in critical care environments, including critical access hospital emergency departments, hospitals and hospital clinics, emergency rooms, intensive care units, cardiac catheterization laboratories, health centers, urgent care centers and many other sites. NPs already perform the care planning and oversee the care delivery for patients with complex conditions, including conditions that would qualify patients for cardiac and pulmonary rehabilitation, in programs such as the Program for All-Inclusive Care for the Elderly (PACE), the Medicare and Medicaid home health programs and through full practice authority within the Veteran's Health Administration. Authorizing NPs to order and supervise these safe and effective services will allow them to be involved in their patients' cardiac and pulmonary rehabilitation care from start to finish, creating greater continuity of care and access for patients.

Support for Removing Barriers to Practice on Nurse Practitioners

Removing barriers to care for NPs and their patients has also garnered widespread bipartisan support. In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[27] the Brookings Institution,[28] the Federal Trade Commission[29] and the U.S. Department of Health and Human Services under multiple administrations[30,31,32] have all highlighted the positive impact of removing barriers on NPs and their patients. The National Academies of Science, Engineering and Medicine report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* also recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[33] The World Health Organization's *State of the World's Nursing 2020* report similarly recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, noting the positive impact it would have on addressing health care disparities and improving health care access within vulnerable communities.[34]

[27] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[28] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[29] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[30] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[31] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[32] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[33] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf
[34] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf

Experience has also shown that removing restrictions on NP practice improves access to care for patients in rural and underserved communities, reduces unnecessary complications, lowers costs and improves quality of life. Currently, 24 states, D.C. and 2 territories are considered Full Practice Authority (FPA).[35] No state has ever moved away from FPA once it has been enacted. States that restrict the legal authorization of NPs to practice their profession limit patient choice and decrease access to care, with particularly acute effects in rural areas.[36]

States that adopt FPA have found overall positive rural health care workforce trends. Arizona adopted FPA in 2001 and found that "the number of Arizona licensed NPs in the state increased 52% from 2002 to 2007", with the largest increase occurring in rural areas.[37] Other states that have reported similar workforce trends include Nevada,[38] Nebraska[39] and North Dakota.[40] South Dakota also reported reduced administrative costs after adopting FPA.[41] These results highlight the importance of removing barriers to practice on NPs to increase access to care for patients.

Conclusion

AANP appreciates the Committee's inclusion of H.R. 1956 the "*Increasing Access to Quality Cardiac Rehabilitation Care Act of 2021*" in this hearing. This important legislation would increase access to lifesaving cardiac and pulmonary rehabilitation for patients and we urge the Committee to advance it. We look forward to further efforts to improve access to high-quality, medically necessary care for all patients.

[35] https://www.aanp.org/advocacy/state/state-practice-environment.
[36] https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.
[37] http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf.
[38] https://www.healthaffairs.org/do/10.1377/hblog20181211.872778/full/.
[39] Holmes, L. R., Assistant, F. C., & Waltman, N. (2019). Increased access to nurse practitioner care in rural Nebraska after removal of required integrated practice agreement, *31*(5).
[40] https://cnpd.und.edu/research/_files/docs/cnpd-ndnpwfreport.pdf.
[41] http://sdlegislature.gov/docs/legsession/2017/FiscalNotes/fn61A.pdf.