November 29, 2019

The Honorable Danny Davis, The Honorable Terri Sewell
The Honorable Brad Wenstrup, The Honorable Jodey Arrington
Co-Chairs
Rural and Underserved Communities Health Task Force
Committee on Ways & Means
1102 Longworth HOB
Washington D.C. 20515

RE: Rural Access to Health Care Services Request for Information (RFI)

Dear Task Force Co-Chairs Davis, Sewell, Wenstrup, and Arrington,

The American Association of Nurse Practitioners (AANP), representing more than 270,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to comment on this RFI related to improving health care services in rural and underserved communities. AANP is committed to working with the Committee on Ways and Means Rural and Underserved Communities Task Force (Task Force) to continue to improve access to high-quality health care in rural and underserved communities.

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 walks of life. 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 long-term care facilities, clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, 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. NPs complete more than one billion patient visits annually.

One of the primary issues facing our rural health care system is a clinician shortage, particularly for primary care, that is being exacerbated by an aging population. NPs have long been recognized for providing high-quality[1], cost-effective[2] care in rural communities. Approximately 73% of all NP graduates deliver primary care[3] and NPs comprise at least 25% of our rural primary care workforce, with that percentage growing annually.[4] As of 2017, there were more than 130,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated

[1] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[2] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[3] https://www.aanp.org/about/all-about-nps/np-fact-sheet.
[4] Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners.

provider specialty.[5] NPs are the second largest provider group in the National Health Services Corps.[6] Despite the health care needs of rural communities, and decades of evidence showing that NPs deliver high-quality, cost-effective care, state and federal barriers continue to inhibit NPs from practicing to the full scope of their education and clinical training.

Removing federal and state barriers for NPs and their patients has garnered widespread bipartisan support. Reports issued by the American Enterprise Institute[7], the Brookings Institution[8], the Federal Trade Commission[9] and HHS[10],[11],[12] have highlighted the positive impact that removal of NP practice barriers has for rural communities. Below is our response to specific questions in the Task Force's RFI. We look forward to working with the Task Force to improve health care in rural communities.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Successful treatment models in rural communities utilize all members of the health care workforce, including NPs, to the full extent of their education and clinical training, leverage available technology (e.g. telehealth and remote patient monitoring) to increase access, empower patients to manage their health care needs, and incorporate community resources. We encourage the review of the Mississippi Diabetes Telehealth Network pilot program which improved patient health and reduced unnecessary hospitalizations and complications using these methods.[13]

NPs are skilled in these imperative interventions, which are necessary in rural areas where resources are limited. NPs were early adopters of the Patient Centered Medical Home model which successfully incorporates care coordination, care planning and consistent patient outreach. CMS recently revised the conditions of participation for the Program of All-Inclusive Care for the Elderly (PACE) to authorize NPs to lead the medical team recognizing the high-quality care that NPs provide to a complex patient population. A recent Veterans Affairs study also found that complex patients with diabetes managed by NPs and PAs had equivalent quality outcomes, and substantially lower care costs than patients managed by physicians.[14] As the Task Force evaluates successful rural health care models, these programs demonstrate the importance of including NPs in the models and authorizing them to practice to the full extent of their education and clinical training.

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/PROVIDERS/2017_CPS_MDCR_PROVIDERS_6.PDF
[6] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf.
[7] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[8] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[9] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[10] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf;
[11] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[12] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[13] https://365.himss.org/sites/himss365/files/365/handouts/550235296/handout-264.pdf.
[14] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00014.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

Urging states to remove restrictions on NP practice improves access to care for patients in rural areas, reduces unnecessary complications, lowers costs and improves quality of life. Currently, twenty-two states and D.C. are considered Full Practice Authority (FPA) states because their licensure laws allow full and direct access to NPs. No state has ever moved away from FPA once it has been enacted. In FPA states, NPs are authorized to practice to the full extent of their education and clinical training without a regulated relationship with a physician. In FPA states, the major barriers to practice are federal restrictions in the Medicare and Medicaid programs.

FPA states have found overall positive rural health care workforce trends. Arizona adopted FPA in 2001 and the number of licensed NPs in the state increased 52% from 2002 to 2007, with the largest increase occurring in rural areas.[15] Other states that have reported similar workforce trends include Nevada[16], Nebraska[17] and North Dakota[18]. South Dakota reported reduced administrative costs after adopting FPA.[19] We ask the Task Force to urge states to remove practice restrictions on nurse practitioners and authorize them to practice to the full extent of their education and clinical training.

7. Access to providers that address oral, behavioral and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Medication assisted-treatment (MAT) has been proven to be an important treatment regimen that decreases opioid use, opioid related deaths, criminal activity and infectious disease transmission.[20] NPs are authorized to prescribe MAT for their patients. SAMHSA reports that over 13,500 NPs have obtained the MAT waiver with over 2,000 waived to treat up to 100 patients.

While NPs have greatly increased access to MAT, recent studies have found that restrictive practice environments are associated with fewer NPs obtaining MAT waivers.[21] The Medicaid and CHIP Payment and Access Commission (MACPAC) also found that the number of NP prescribing buprenorphine for the treatment of opioid use disorder (OUD) and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year NPs were authorized to obtain their MAT waiver, particularly in rural areas and for Medicaid beneficiaries.

[15] http://azahec.uahs.arizona.edu/sites/default/files/u9/azworkforcetrendanalysis02-06.pdf.
[16] https://www.healthaffairs.org/do/10.1377/hblog20181211.872778/full/.
[17] 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).

[18] https://cnpd.und.edu/research/_files/docs/cnpd-ndnpwfreport.pdf.
[19] http://sdlegislature.gov/docs/legsession/2017/FiscalNotes/fn61A.pdf.
[20] https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.
[21] https://jamanetwork.com/journals/jama/fullarticle/2730102?widget=personalizedcontent&previousarticle=2737024.

However, MACPAC also found that NPs in restrictive practice states were less likely to obtain their MAT waiver than NPs in FPA states.[22]

This disparity between FPA states and non-FPA states is in part due to federal law stipulating that if a state requires an NP to maintain a collaborative or supervisory agreement with a physician, that physician must also have completed the MAT certification course or be board certified in addiction medicine or addiction psychiatry for the NP to provide MAT. The Task Force should recommend revising this requirement so NPs who have completed the training and obtained their waiver can provide MAT regardless of physician status.

8. The availability of post-acute care and long-term services and supports is limited across the nation, but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

Based on our experiences, we encourage the Task Force to support the following policies to improve post-acute care and long-term care for NPs and their patients:

- *Improve Medicare Patient Access to Home Health Care Services*

We encourage the Task Force and all members of this committee to support H.R. 2150 the *"Home Health Care Planning Improvement Act of 2019"* which would authorize NPs and PAs to certify and recertify home health care plans. Further, we urge the Task Force to ensure that the full House Ways & Means Committee takes up H.R. 2150 as quickly as possible.

- *Cardiac and Pulmonary Rehabilitation (CR and PR)*

We encourage the Task Force and all members of this committee to support H.R. 3911 the *"Increasing Access to Quality Cardiac Rehabilitation Care Act of 2019"* which would authorize NPs and PAs to order and supervise CR and PR. Further, we urge the Task Force to ensure that the full House Ways & Means Committee takes up H.R. 3911 as quickly as possible.

- *Hospice Certification*

We encourage the Task Force to support legislation that would authorize NPs to certify a patient is terminally ill and in need of hospice care.

- *Skilled Nursing Facility (SNF) Admitting Examinations and Bi-Monthly Assessments*

We encourage the Task Force to support modernizing SNF conditions of participation to authorize NPs to admit patients and perform the admitting assessment and all required monthly/bimonthly patient assessments.

[22] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

In addition to those already discussed, we encourage the Task Force to support the following policy efforts:

- *Improve Medicare Patient Access to Needed Diabetic Shoes*

We encourage the Task Force and all committee members to support H.R. 808 the *"Promoting Access to Diabetic Shoes Act"* which would authorize NPs to certify their patients' needs for diabetic shoes. We urge the Task Force to ensure that the full House Ways & Means Committee takes up H.R. 808 as quickly as possible.

- *Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)i*

We encourage the Task Force to request that CMS amend these regulations to align with the statute ensuring NPs can direct and practice in RHCs and FQHCs in accordance with State law.

- *Medicaid Clinic Services*

We encourage the Task Force to recommend changing the statute so States can utilize their workforce to their full scope and allow NPs to direct Medicaid clinic services.

- *Home Infusion Therapy*

Authorize NPs to establish and review their Medicare patients' care plan for home infusion therapy. NPs provide home visits and create care plans and treat patients receiving infusion therapy in their offices and other settings without physician certification.

- *Black Lung Program*

Authorize NPs to diagnose, treat and certify the presence of pneumoconiosis for the Black Lung Program. This will reduce provider burden and improve access to care for coal miners who see NPs as their primary clinicians.

- *Medical Nutrition Therapy*

Authorize NPs to refer their Medicare patients for medical nutrition therapy.[23]

[23] 42 U.S.C. § 1395x(vv).

We thank the Task Force for the opportunity to comment on ways to improve access to care in rural communities. We look forward to further engagement on this important issue. Should you have comments or questions, please contact MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org.

Sincerely,

David Hebert
Chief Executive Officer