June 26, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: CMS-1688-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

RE: CMS-1688-P - Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019 (83 Fed. Reg. 20972, May 8, 2018).

The American Association of Nurse Practitioners (AANP), representing more than 248,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment in response to the fiscal year 2019 updates to the Inpatient Rehabilitation Facility Prospective Payment System (83 FR 20972).

NPs are advanced practice registered nurses 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 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. It is important to note that 86.6% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually.

Solicitation of Comments Regarding changes to the Use of Non-Physician Practitioners in Meeting the Requirements Under § 412.622(a)(3), (4), and (5)

In this proposed rule, CMS noted that commenters to the FY 2018 IRF proposed rule suggested expanding the use of nurse practitioners and physician assistants within IRFs to relieve the burden on those facilities. CMS is seeking feedback from stakeholders on the expanded usage of NPs and PAs, specifically on allowing NPs and PAs to perform and document the post-admission assessment and required face-to-face visits. CMS has asked four questions regarding the proposals related to the post-admission assessment and required face-to-face visits which we answer below. We thank CMS for listening to stakeholders on this issue, and we fully support these proposals.

1. *Do non-physician practitioners have the specialized training in rehabilitation that they need to have to assess IRF patients both medically and functionally?*

NPs are well prepared and already provide care in IRFs. However, a physician must still perform certain assessments and visits that NPs are perfectly capable of performing in order to meet regulatory requirements for these facilities. As you know, NPs are advanced practice registered nurses who are prepared at the masters or doctoral level to provide acute and chronic care to patients in all settings including IRFs.

As we have stated, educational preparation provides NPs with specialized knowledge and clinical competency enabling them to make differential diagnoses, initiate and manage treatment plans including prescribing medications and treatments. NP educational programs include didactic and clinical experiences to prepare graduates for advanced clinical practice. Their accreditation requirements, and competency-based standards ensure that NPs are equipped to provide safe, high-quality patient care upon graduation. Competencies acquired through mentored patient care clinical experience emphasize the management of patients within the complexities of the health care delivery system and emphasize independent and interprofessional practice. Clinical competency and professional development are hallmarks of NP education.

These educational and clinical experiences prepare NPs to assess IRF patients medically and functionally, NPs already perform these assessments in other settings including inpatient hospitals, skilled nursing facilities and hospice. It is important to note that this proposal would provide the IRF with more flexibility to appropriately utilize their medical staff.

2. *How would the non-physician practitioner's credentials be documented and monitored to ensure that IRF patients are receiving high quality care?*

An NP's credentials would be documented and monitored in the same fashion that a physician's credentials would be documented and monitored. NP's must meet extensive educational, certification and licensure requirements prior to being able to practice as an NP, and would meet privileging requirements of the facilities in which they practiced.

NP students graduate from accredited academic programs, as described in our response to question one. They must achieve national certification by an accredited NP certification body in order to be licensed. Certification indicates that NPs have successfully met educational and clinical requirements and have passed an approved comprehensive, psychometrically sound examination of their professional knowledge.

After graduating from an accredited program and achieving national certification, graduates apply for licensure through their State Board of Nursing. The state Board of Nursing verifies that NPs meet all educational requirements, and any additional state requirements necessary for NP licensure, before granting a license to practice as an NP. To reiterate, there is a stringent process of education, certification, licensure and accreditation to ensure that NPs are providing the highest quality care to their patients.

In addition, NPs would go through the privileging process required of medical staff. IRFs ensure that providers have the proper competence and credentials during the hiring process, and under Medicare regulations facilities must have medical staff bylaws that determine the criteria that a provider must meet to obtain staffing privileges.[1]

[1] 42 CFR § 482.22.

3. *Are non-physician practitioners required to do rotations in inpatient rehabilitation facilities as part of their training, or could this be added to their training programs in the future?*

Clinical practice is a hallmark of NP education and NPs must demonstrate clinical competency before obtaining their degree. NPs acquire the skills to diagnose and manage patients in rehabilitation in a variety of settings during their educational program. In addition, NPs have extensive clinical training prior to their NP program through their undergraduate education or practice as a registered nurse.

4. *Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact of the quality of care for IRF patients?*

We believe that authorizing NPs who have a long history of providing safe, high quality care to their patients would improve the care for IRF patients by reducing the burden on other members of the patient's clinical care team, and authorizing facilities to utilize their staff in the most efficient way possible. NPs are valuable providers in IRFs and have extensive experience assessing; 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 are qualified and experienced at performing and documenting mandatory assessments such as those of IRF patients and maintaining the high quality of care these patients require.

CMS requested feedback on whether NPs had the training and clinical capability to treat the complex patients in an IRF. We would like to note that the patients treated by NPs are already as complex as IRF patients. Based on CMS data, the average HCC risk score for Medicare Part B patients treated by NPs is 1.78, and 28.6% of NP Medicare patients are dual eligibles. These numbers are actually higher than physical medicine and rehabilitation physicians who treat Medicare patients with an HCC risk score of 1.76 and 27% of their Medicare patients are dual eligibles.[2] NPs have a history of treating complex patients across all settings, and already doing so in IRFs. Authorizing NPs to perform these assessments is consistent with assessments that they are authorized to provider in other settings such as inpatient hospitals, skilled nursing facilities, and hospice as well as outpatient rehabilitation centers.

Studies have consistently demonstrated the excellent outcomes and high quality of care provided by NPs across all settings and in treating complex patients.[3] NPs have demonstrated that the care they provide is comparable in quality to their physician colleagues in settings such nursing homes[4], primary care[5], and hospital emergency departments[6], and in treating complex patients such as those with diabetes[7] and

[2] 82 FR 30010, 30137.
[3] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[4] Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. Research in Gerontological Nursing, 1(3), 177-185. doi: 10.3928/00220124-20091301-01.
[5] Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44(6), 332-9.
[6] Carter, A., Chochinov, A. (2007). A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department. Canadian Journal of Emergency Medicine, 9(4), 286-95.
[7] Kuo, Y., Chen, N., Baillargeon, J., Raji, M. A., & Goodwin, J. S. (2015). Potentially Preventable Hospitalizations in Medicare Patients With Diabetes: A Comparison of Primary Care Provided by Nurse Practitioners Versus Physicians. Medical Care, 53(9), 776-783. doi:10.1097/MLR.0000000000000406

cardiovascular disease.[8] In one report for instance, a rehabilitation facility case study highlighted the importance of NPs in IRFs and noted that NPs already perform these assessments in the ambulatory rehabilitation setting, and with the required physician involvement in the inpatient setting. Authorizing NPs to perform these assessments in an IRF without duplicative physician involvement will expand the ability of the entire care team to provide high-quality care to IRF patients.[9]

In addition, in the 2018 Hospital Outpatient Prospective System Final Rule, CMS reinstated the non-enforcement instruction for the supervision of outpatient therapeutic services in critical access hospitals and small rural hospitals, authorizing NPs and other qualified practitioners to provide treatment without physician supervision. In this Final Rule, CMS stated that they were not aware of any decrease in quality of care during the years that the non-enforcement instruction was in place.[10] This further demonstrates that NPs have been recognized as providing high quality care to patients with rehabilitative and therapeutic needs.

Proposed Changes to the Admission Order Documentation Requirement Beginning With FY 2019

We agree with CMS that eliminating duplicative requirements will reduce unnecessary administrative burden and confusion, and we support the proposed changes to the IRF admission order documentation requirements. Since an IRF already must meet the hospital admission order conditions of participation and payment requirements, 42 CFR § 412.606(a) is redundant and unnecessary.

Interdisciplinary Team Meetings

CMS also discusses the structure of the interdisciplinary team meetings in IRFS and providing more flexibility to conduct aspects of the team meeting via telecommunication. NPs also have the training and competency to lead the interdisciplinary team meetings, and we ask CMS to consider authorizing NPs to lead the team meetings in future rulemaking to continue providing flexibility to IRFs.

We thank you for the opportunity to comment on this proposed regulation and for listening to stakeholders on the increased role that NPs should have in IRFs. We look forward to discussing these issues with you. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer

[8] Virani, S. S., Maddox, T. M., Chan, P. S., Tang, F., Akeroyd, J. M., Risch, S. A., & ... Petersen, L. A. (2015). Provider Type and Quality of Outpatient Cardiovascular Disease Care: Insights From the NCDR PINNACLE Registry. Journal of the American College of Cardiology, 66(16), 1803-1812. doi:10.1016/j.jacc.2015.08.017

[9] Kosevich, Gwen, Leinfelder, Anna, Sandin, Karl J., Swift, Erin, Taber, Susan, Weber, Rebecca, Finkelstein, Marsha. (2014). Nurse practitioners in medical rehabilitation settings: A description of practice roles and patterns. Journal of the American Association of Nurse Practitioners,194-201.

[10] 82 FR 59216, 59390.