Increasing Access to Quality Cardiac Rehabilitation Care Act of 2019
H.R. 3911

The Issue
The undersigned organizations support legislation that would authorize physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs), referred to as advanced practice providers (APPs), to begin *supervising* patients' day-to-day cardiac and pulmonary rehabilitation care (CR/PR) in 2020 – rather than 2024 – as a way to expand patient access to cardiovascular services. In addition, H.R. 3911 would authorize APPs to *order patients to* cardiac and pulmonary rehabilitation under Medicare. These important provisions would help increase patient access to cardiovascular care, especially in underserved and rural areas.

The Legislation
Last year, Congress passed the *Improving Access to Cardiac and Pulmonary Rehabilitation Act* as part of the *Bipartisan Budget Act of 2018* (P.L. 115-123). This legislation would build upon that success by authorizing APPs to provide direct supervision for cardiac and pulmonary rehabilitation beginning in 2020 – four years earlier than under current law. It would also authorize APPs to order cardiac and pulmonary rehabilitation services.

Background
Cardiac rehabilitation (CR) and pulmonary rehabilitation (PR) are medically directed and supervised programs designed to improve a patient's physical, psychological, and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment and outcomes assessment. Coronary heart disease patients who enroll in CR have a 26% lower risk of CVD-related death and an 18% lower risk of readmission at 1-year follow-up compared to those who don't enroll.[1] However, despite these benefits, participation in cardiac rehab remains low. Only a third of patients referred to CR attend at least one session[2] and rates are 30% lower for individuals who live outside of metropolitan areas and 42% lower for those who live in economically-deprived urban communities.[3] Research found that women were 12% less likely to be referred than men, and Blacks, Hispanics, and Asian patients were 20%, 36%, and 50% less likely to be referred than White patients.[4] Positive outcomes from pulmonary rehabilitation include increased exercise tolerance, reduced dyspnea

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[1] Anderson L, Thompson DR, Oldridge N, Zwisler A, Rees K, Martin N, Taylor RS. Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews 2016, Issue 1. Art. No.: CD001800. DOI: 10.1002/14651858.CD001800.pub3

[2] Doll JA, Hellkamp A, Ho PM, et al. Participation in Cardiac Rehabilitation Programs Among Older Patients After Acute Myocardial Infarction. *JAMA Intern Med.* 2015;175(10):1700–1702. doi:10.1001/jamainternmed.2015.3819

[3] M. Bachmann, Justin & Huang, Shi & K. Gupta, Deepak & Lipworth, Loren & T. Mumma, Michael & Blot, William & Akwo, Elvis & Kripalani, Sunil & A. Whooley, Mary & J. Wang, Thomas & S. Freiberg, Matthew. (2017). Association of Neighborhood Socioeconomic Context With Participation in Cardiac Rehabilitation. Journal of the American Heart Association. 6. e006260. 10.1161/JAHA.117.006260.

[4] 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:

and anxiety, increased self-efficacy, reduced and shortened hospital admissions, and improvement in health-related quality of life.[5, 6] Despite these benefits, only approximately 3 percent of Medicare beneficiaries with chronic obstructive pulmonary disease (COPD) receive pulmonary rehabilitation.[7]

Many people who can benefit from CR and PR programs are not being referred. Automatic, systematic referral to CR and PR programs at discharge can help connect eligible people with these programs. Long wait times following discharge also reduce CR enrollment. For every day a person waits to start CR, that person is increasingly less likely to enroll. Authorizing APPs to order cardiac rehabilitation would help facilitate immediate referral of patients.

APPs routinely serve as frontline medical 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. APPs are highly trained to respond should emergencies arise. We believe it is appropriate to authorize qualified APPs to order, as well as supervise, these safe and effective services. Granting ordering authority to APPs would allow these qualified providers to be involved in their patients cardiac and pulmonary rehabilitation care from start to finish. APPs would be able to establish, review, and sign individualized treatment plans for their patients which specify the patient's diagnosis, the type, amount, frequency, and duration of treatment services, and individualized goals.

Under current Medicare law, only physicians are authorized to order the need for or order cardiac or pulmonary rehabilitation for Medicare patients, even though qualified APPs are often authorized to perform such services under state law, often serve as primary care providers for patients, and are often the providers most familiar with the needs of their patients. In some cases, an ordering physician may not have a relationship with the patient and must rely on the recommendation of the nurse practitioner, physician assistant, or clinical nurse specialist to order rehabilitation services. In too many cases, these requirements create obstacles, delays, and unnecessary paperwork before patients can receive rehabilitation services that are needed on a timely basis. Congress has acknowledged that current law imposes a more stringent requirement for direct physician supervision for CR and PR than should be required, making it challenging for CR and PR programs to operate in areas where physicians are scarce and imposing unnecessary costs in both rural and urban areas.

Supporters (Supporter List in Development)

- **American Academy of PAs**
- **American Association for Respiratory Care**
- **American Association of Cardiovascular and Pulmonary Rehabilitation**
- **American Association of Nurse Practitioners**
- **American College of Cardiology**
- **American Heart Association**
- **National Association for Medical Direction of Respiratory Care**
- **Preventive Cardiovascular Nurses Association**
- **WomenHeart**

We urge Members of Congress to sign on to the Increasing Access to Quality Cardiac Rehabilitation Care Act of 2019 (H.R. 3911). For more information about the bill or to sign as a cosponsor, please contact Thomas Dorney in Representative John Lewis's office at thomas.dorney@mail.house.gov or Joel Keralis in Representative Adrian Smith's office at joel.keralis@mail.house.gov.

10.1161/JAHA.117.008088

[5] Casaburi R, ZuWallack R. Pulmonary rehabilitation for management of chronic obstructive pulmonary disease. *N Engl J Med* 2009;360:1329–1335.

[6] Griffiths TL, Burr ML, Campbell IA, Lewis-Jenkins V, Mullins J, Shiels K, *et al*. Results at 1 year of outpatient multidisciplinary pulmonary rehabilitation: a randomised controlled trial. *Lancet* 2000;355:362–368. [Published erratum appears in *Lancet* 355:1280.]

[7] Nishi SP, Zhang W, Kuo YF, Sharma G. Pulmonary rehabilitation utilization in older adults with chronic obstructive pulmonary disease, 2003 to 2012. *J Cardiopulm Rehabil Prev* 2016;36:375–382.