American Occupational Therapy Association

October 13, 2023

TO: U.S. House of Representatives Budget Committee

FROM: American Occupational Therapy Association

RE: Request for Information: Health Care Task Force

Submitted electronically: *hbcr.health@mail.house.gov*

To Whom it May Concern,

On behalf of the American Occupational Therapy Association (AOTA), I want to thank you for the opportunity to comment on suggestions to improve health outcomes while also driving down spending and lowering the Medicare cost curve. Occupational therapy is focused on enabling patients to maximize their ability to participate in daily occupations whether that be simply making a meal and navigating safely through their home, toileting, driving, or participating in other activities of daily living. Failure to safely participate in such basic activities can lead to falls, accidents or other incidents that result in emergency room visits, hospitalizations and often institutionalization. By preventing or even delaying such outcomes, occupational therapy serves to lower overall healthcare costs, especially among Medicare beneficiaries.

AOTA is the national professional association representing the interests of more than 230,000 occupational therapists, occupational therapy assistants and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting participation in daily occupations or activities. In so doing, growth, development and overall functional abilities are enhanced, and the effects associated with illness, injuries and disability are minimized.

Topics:

- *Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending*
- *Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs*
- *Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes*

Cost Savings Through Supporting Aging in Place and Reducing Falls

Multiple programs and studies have demonstrated the effectiveness and cost savings of an occupational therapy led home-safety evaluation centered on a client's identified goals and preferences and followed by suggested low-cost home modifications and adaptive equipment. Despite demonstrated cost savings and improved quality of life, there is no way for these types of services to be provided to Medicare beneficiaries outside of grant funding and demonstration projects.

The CAPABLE Model which was developed through funding by the Center for Medicare and Medicaid Innovation (CMMI) and the National Institutes of Health is the most well-known of these interventions. This five-month, interprofessional, team-based intervention is delivered by an occupational therapist (six visits), a nurse (4 visits), and a handy-person (up to one day). The handy-person will make home repairs, install assistive devices, and make home modifications as prescribed by the occupational therapist. CAPABLE as

a model promotes safe and effective aging in place by addressing Medicare beneficiary issues that directly drive healthcare costs yet are not addressed in current care models. The model has resulted in reduced disability, healthcare cost savings, and the promotion of aging in place. Studies have demonstrated that the CAPABLE model produced $922 per Medicare beneficiary per month in savings for up to 2 years[1] and $867 per month for up to a year in Medicaid savings[2] due to a reduction in hospitalizations and other institutional based care.

While the CAPABLE model has undergone multiple clinical trials and studies, there is other ample evidence for the cost-effectiveness of low cost, high intensity home modifications directed by an occupational therapist. A study in the *American Journal of Preventative Medicine* identified "home modifications delivered by an occupational therapist" as the intervention with the greatest potential to help older adults by preventing falls. The study estimated a cost savings of $38.2 million and estimated that 45,164 falls would be prevented[3]. Another study combined weatherization/energy services with a home safety assessment conducted by an occupational therapist and subsequent home modifications/repairs. The study group saw a significant reduction in falls (from 94% to 9%) and calls for assistance (from 23% to 3%) within a 6-month period[4].

When Congress directed the Department of Housing and Urban Development (HUD) to establish a grant program to help enable low-income elderly persons to remain in their primary residence, HUD chose OT to lead home modifications as the intervention with the most evidence of success and cost savings and also based the Older Adults Home Modification Grant Program (OAHMP) around this intervention model[5]. The grant program highlights that occupational therapy practitioners are "trained to evaluate clients' functional abilities and the home environment" and have "knowledge of the range of low-cost, high-impact environmental modifications and adaptive equipment used to optimize the home environment and increase independence."

Congress has established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) so that ideas on value-based care could be generated from the diverse provider community. The ability of the PTAC to approve smaller, innovative Alternative Payment Models (APMs) is now more important than ever, as CMMI has pledged to focus on fewer, larger APMs. Despite the promise of the PTAC, however, it has failed to create a pathway for meaningful participation in APMs. The CAPABLE model is an example of an evidence-based intervention, approved by the PTAC, that was never implemented by CMS even though it was first developed through funding from CMMI research grants.

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Recommendations:

Congress could allow healthcare practitioners to pilot test PTAC-approved APM models: This is not allowed under current law, but granting such permission would allow participants to show CMS and other policymakers how the model would work and perform in real-world settings for the benefit of Medicare beneficiaries. Once the pilot period concludes and an appropriate amount of data was collected and analyzed, CMS could make its final approval or denial decision. If approved, this would allow for other providers to more easily replicate real-world use of the piloted model and build upon lessons learned to allow for more effective, broad-scale implementation.

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[1] Ruiz S, Snyder LP, Rotondo C, Cross-Barnet C, Colligan EM, Giuriceo K. Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use. Health Affairs. 2017;36(3):425-432.
[2] Szanton SL, Alfonso YN, Leff B, et al. Medicaid Cost Savings of a Preventive Home Visit Program for Disabled Older Adults. Journal of the American Geriatrics Society. 2018;66(3):614-620.
[3] Stevens, Judy A. and Robin Lee. "The Potential to Reduce Falls and Avert Costs by Clinically Managing Fall Risk." *Am J Prev Med* 55 no. 3 (2018): 290–297. doi:10.1016/j.amepre.2018.04.035
[4] Tohn, Ellen, Jonathan Wilson, Tracy Van Oss, and Michael Gurecka. "Incorporating Injury Prevention into Energy Weatherization Programs." *J Public Health Manag Pract* (2019) doi:10.1097/PHH.0000000000000947

[5] https://www.hud.gov/program_offices/spm/gmomgmt/grantsinfo/fundingopps/oahmp

Congress must be able to look beyond current CBO analysis when judging potential savings for innovative programs: Under current rules, CBO would not take into account the massive savings which would be generated by a national roll-out of CAPABLE or a similar program. Therefore, the cost would be prohibitively high, and real savings would not be realized as patients would continue to suffer preventable accidents which result in costly emergency room visits, hospitalizations and institutionalization.

Reduce Regulatory Burden to Allow Greater Use of Occupational Therapy Assistants

Access to occupational therapy is directly dependent on the availability of occupational therapy assistants (OTAs) who can provide most OT services under supervision of an occupational therapist. On January 1, 2022, Medicare outpatient services provided by OTAs and physical therapist assistants (PTAs) began receiving a 15% reduction in payment. This cut is the result of a provision in the Balanced Budget Act of 2018, and is separate from, and in addition to, other cuts to therapy payments under the Medicare Physician Fee Schedule that have been imposed over the last several years. In addition, Medicare applies burdensome regulatory restraints related to supervision requirements of OTAs and PTAs in private practice settings which limits access and can actually increase costs given the new reimbursement policies.

Recommendation:

Enact the *Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation* (EMPOWER) Act (H.R. 4878/S. 2459): The EMPOWER Act would change the Medicare supervision requirement for OTAs and PTAs in private practice so that it cannot exceed requirements under State law. Currently, private practice is the only setting under Medicare Part B that requires "direct" supervision instead of "general" supervision. Therapy providers in all settings must comply with their state practice act if state or local practice requirements are more stringent than Medicare, and currently 48 states require general supervision of physical therapist assistants, and 49 states require general supervision of occupational therapy assistants. This Medicare regulation which only applies to private practices is also more burdensome than in all other settings including those where more acute patients are generally seen, i.e. hospital outpatient/SNF, etc.

A study by Dobson DaVanzo and Associates indicates that there would be a 10-year savings to the Medicare program of at least $233.8 million based on an increase in services provided by OTAs and PTAs at the 15% discount from the same services provided by OTs. This was based on an analysis of other instances where supervision requirements were relaxed for other provider types including advanced practice nurses, physician assistants, and dental hygienists.

Topics:

- *Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes*
- *Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes*

Telehealth has enabled innovative OT services that cannot be replicated in clinics

The dramatic expansion of telehealth after the onset of the Covid-19 pandemic drove occupational therapy innovation and resulted in the development of techniques that greatly enhanced existing services including some that cannot be replicated in a clinical/office setting. Among the most innovative OT services enabled by telehealth, virtual "home tours" conducted by OTPs are used now to identify home safety issues that would never be identified by the patient in a facility/office setting. This can be crucial in preventing falls, addressing functional decline, and avoiding costly emergency room visits and hospital admissions which can reduce the cost of care.

The CAPABLE study and others have demonstrated real savings when Medicare beneficiaries address home safety issues under the direction of an OTP, and OT via telehealth grants remote access to a patient's home to first identify and then address these issues. This OT service which brings great benefits to Medicare patients will cease to be available if Congress does not act to make OTPs permanent telehealth providers in Medicare.

Recommendation:

Congress should enact legislation to establish OTPs as Medicare telehealth providers: Prior to the public health emergency (PHE), OTPs were not eligible to provide services to Medicare beneficiaries via telehealth. CMS has the authority to create CPT therapy telehealth codes, and it has done so, but it cannot list OTPs or other therapists as Medicare telehealth providers. Waivers enacted by Congress and implemented by CMS for the duration of the PHE and beyond have been extended to the end of 2024; however, Congress must act to make these waivers permanent.

Representatives Mikie Sherrill (D-NJ) and Diana Harshbarger (R-TN) have introduced the Expanded Telehealth Access Act (HR3875) which would specifically establish OTPs as well as physical therapists, speech language pathologists and audiologists as Medicare telehealth providers. Senators Steve Daines (R-MT) and Tina Smith (D-MN) have reintroduced a companion bill in the Senate, S.2880.

AOTA also notes that the CONNECT for Health Act (HR4189/S2016) was introduced to address myriad issues related to the continuation of telehealth in Medicare, and that this bill does at least give CMS the authority to establish OTPs and other therapists as telehealth providers. While this is a step in the right direction, we urge support of legislation such as HR3875 that would make Congress's intent to add OTPs as telehealth providers clear.

This clarity is particularly important to eliminate any uncertainty related to therapy telehealth services billed through a facility. OTPs providing outpatient services in settings such as hospital outpatient departments are not allowed to bill through their own provider number, instead their services are billed through the facility. When CMS was implementing telehealth waivers enacted in December 2022, they misinterpreted the clear intent of Congress, and reported to providers in facility-based settings, including hospital outpatient departments, that therapy via telehealth would end with the PHE. Fortunately, CMS reversed this decision for the remainder of 2023, and then proposed to extend all waivers, as Congress intended, in their 2024 Physician Fee Schedule. However, Congress has established every other telehealth provider in Medicare through legislative action, and it should do the same with therapy providers to avoid such confusion.

Access to OT Services in the Home Reduces Healthcare Spending

Older Americans face unique healthcare access issues, and occupational therapists have long been recognized as critical providers of home health care services under Medicare Part A; however, occupational therapy is the only skilled service that does not *qualify* a beneficiary for the Part *A* home health benefit. As a result, OT services cannot be provided in a beneficiary's home unless nursing or other therapy services are simultaneously ordered at the start of care. This can result in Medicare beneficiaries not receiving occupational therapy services that would enable them to maximize their ability to thrive at home and to avoid costly rehospitalizations unless other disciplines are also ordered. As an example, some beneficiaries with low vision, dementia, diabetes and COPD could receive tremendous benefit from OT services, but may not also require nursing, physical therapy or speech services when home health orders are written.

The vast majority of Medicare beneficiaries would prefer to remain at home rather than in an institutional setting, and enabling this to happen generates significant savings for the Medicare system. OT home health services directly relate to the ability of a patient to safely handle activities of daily living in the home, and as such they directly impact a Medicare beneficiary's ability to avoid costlier outcomes.

Recommendation:

Support passage of the Medicare Home Health Accessibility Act: The MHHA would enable occupational therapy to be ordered as a stand-alone home health service if and when appropriate. Based on legislation enacted in 2020, CMS already allows occupational therapists to conduct the Initial and Comprehensive Assessments required to open a Medicare home health case when it is ordered with either physical therapy or speech language pathology, and this has streamlined home health agency operations. The MHHA would simply enable stand-alone occupational therapy services to be ordered when appropriate, thereby targeting resources as needed and reducing incentives to order other services that might not be needed simply to get OT in the door.

An analysis of the budgetary implications of the bill was conducted by The Moran Company, and the 10-year score was estimated to be $223 million. This figure was developed in adherence to current CBO cost analysis standards which do not take into consideration potential savings related to avoided hospitalizations through the provision of OT services in the home. Such savings have been demonstrated in acute care settings[6], and multiple studies have demonstrated that occupational therapy-led home safety evaluations paired with low-cost modifications decrease disability and result in significant cost savings[7,8,9].

CBO Must Consider Research That Indicates Savings from OT Interventions

While CBO will consider the healthcare savings of services that are by nature preventative (i.e. vaccines), the majority of healthcare services including occupational therapy are only scored from a utilization cost perspective. Scoring only from this perspective will prevent Congress from enacting policies that can improve the long-term health of beneficiaries and ultimately reduce Medicare costs. Any bill that increases access to occupational therapy services is automatically scored based on assumptions of increased utilization. However, multiple research studies, such as the studies around CAPABLE and similar programs have shown that occupational therapy services can decrease the need for hospitalization.

In addition to the studies already mentioned, independent research from health economists at John's Hopkins University found that in an acute care setting, **occupational therapy services were the only category where additional spending had a statically significant association with lower readmission rates** for people with heart failure, pneumonia, and acute myocardial infarction (the three categories studied).[10] CBO scores must be able to take into account research studies such as this when determining the true cost of increasing access to specific services such as occupational therapy.

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Thank you for your efforts to enhance healthcare access while restraining Medicare costs. Please let me know if I can be of further assistance in these efforts by contacting me at abopp@aota.org.

Sincerely,

Andrew Bopp
Senior Legislative Representative

[6] https://journals.sagepub.com/doi/10.1177/1077558716666981
[7] https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15143
[8] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1305
[9] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0140
[10] https://journals.sagepub.com/doi/abs/10.1177/1077558716666981