October 5, 2023

TO: U.S. House of Representatives Ways and Means Committee

FROM: American Occupational Therapy Association

RE: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Submitted electronically: *WMAccessRFI@mail.house.gov*

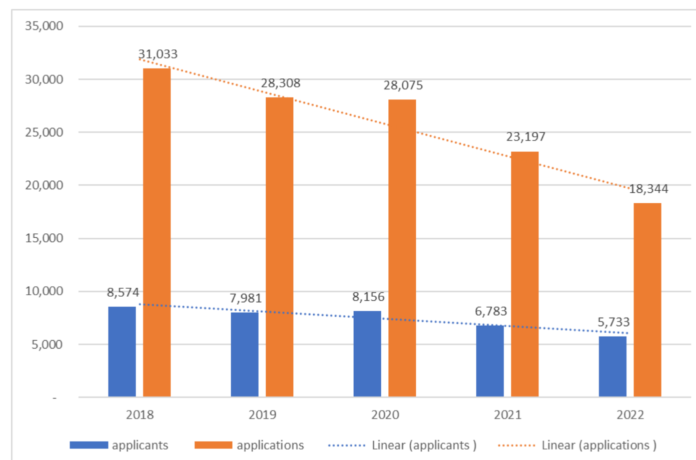
To Whom it May Concern,

On behalf of the American Occupational Therapy Association (AOTA), I want to thank you for the opportunity to comment on disparities in access to healthcare, especially for people in rural and underserved communities and to suggest potential solutions. Rural Americans face unique healthcare challenges related to low population density, aging populations, long distances between patients and providers, and the corresponding low number of available healthcare providers including occupational therapy professionals (OTPs). These rural issues have been exacerbated by workforce shortages throughout healthcare including among OTPs where dramatic declines in applications to academic programs for both occupational therapists and occupational therapy assistants have occurred since the pandemic.

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.

Current Enrollment Trends and Employment Statistics

Healthcare access issues cannot be considered without first examining the state of the healthcare workforce, and this is even more critical in rural and underserved areas where fewer OTPs are available to treat patients. Occupational therapy (OT) services are provided by both occupational therapists (who are trained either through a 2-year master's program or a 3-year doctoral program) and occupational therapy assistants (who either receive an associate degree or a bachelor's degree).



Since 2018, there has been a steady decrease in the number of applicants (-33%) and total applications (-41%) to OT programs. Occupational therapy assistant (OTA) programs have seen the most significant of these declines. In 2015, these programs filled 85% of their available seats. In 2022, only 66% of seats were filled - a 19% decrease.

In the midst of declining applications, the U. S. Bureau of Labor Statistics projects that over the next 10 years, a 14% increase is needed in employment of occupational therapists[1] and a 25% increase in employment of occupational therapy assistants[2]. Occupational therapy services are crucial to a healthcare system that focuses on enabling people to live independently and fully participate in activities important to them, and rural areas face greater burdens in meeting these demands given their greater dependence on occupational therapy assistants which face greater recruitment challenges coupled with larger decreases in OTA school applications.

Question - Geographic Payment Differences: *The Committee is requesting comments on policies to improve existing payment methodologies to end the perpetuation of historical payment inequities and to reduce opportunities for abuse. This includes a review of the area wage index and the geographic practice cost index. Comments should address proposals that ensure adequate payments to health care facilities while avoiding harmful cliffs and perverse incentives. Feedback is also requested on how best to ensure adequate payments to providers without creating unjustified disparities.*

Occupational Therapy Assistants: Access to Care in Rural and Underserved Areas

Access to occupational therapy in rural, medically underserved areas is directly dependent on the availability of occupational therapy assistants. An analysis of 2021 Medicare Part B claims shows that 46% of all occupational therapy services provided in rural and medically underserved areas are provided by OTAs, compared to 34% in all other geographic areas[3]. The recent trends in enrollment for occupational therapy assistant programs are particularly worrisome for rural and medically underserved areas where beneficiaries already tend to receive fewer minutes of therapy in settings such as skilled nursing facilities and where occupational therapy assistants provide a much higher percentage of those minutes[4].

Current enrollment trends and projected workforce needs paint an alarming picture for the future of the occupational therapy workforce and people's ability to access occupational therapy services in rural and medically underserved areas. Compounding the enrollment challenge is a recent reimbursement cut for services provided by OTAs. On January 1, 2022, Medicare outpatient services provided by occupational therapy assistants 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.

Recommendation:

[1] https://www.bls.gov/ooh/healthcare/occupational-therapists.htm#tab-6
[2] https://www.bls.gov/ooh/healthcare/occupational-therapy-assistants-and-aides.htm#tab-6
[3] Dobson|DaVanzo Health Economics Consulting report: "Impact on Medicare Spending of the Stabilizing Medicare Access to Rehabilitation and Therapy Act – Appendix – Detailed Data" analysis of Medicare Carrier and Outpatient Research Identifiable Files for 2021

5 https://www.aota.org/-/media/corporate/files/advocacy/federal/otaworkforceinsnfsfinalreport922.pdf

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..

Enacting this bill would remove barriers to care provided by OTAs in a private practice setting and would reinforce the important role of occupational therapy assistants as part of the care team, especially in rural areas. The bill also requires the Government Accountability Office (GAO) to examine the impact of the 15% payment cut to OTAs and PTAs on access to services in rural and medically underserved areas. AOTA believes strongly that these cuts have already impacted access to services in rural and underserved areas, but more data is needed.

Occupational Therapy Hit Hard by Changes to E/M Values and G2211 Code

In response to your question regarding, "how best to ensure adequate payments to providers without creating unjustified disparities," it is important to understand that occupational therapy practitioners and other therapy providers were particularly hard hit by CMS's recent redistribution of resources on the physician fee schedule to increase payments for Evaluation & Management (E/M) codes. Unlike other medical specialties, therapy providers are not allowed to bill evaluation and management codes, meaning therapy practitioners have taken and will continue to face the full reduction in the conversion factor caused by these payment changes. In addition to the decreases in the conversion factor caused by changes to the E/M values, payment for therapy services will receive an additional cut in 2024 after the Congressional moratorium on implementation of the G2211 code ends.

The negative impacts of past and future budget neutrality cuts on OT are felt nationally; however, rural providers face greater challenges given that they serve smaller and often shrinking patient populations. Total Medicare payments for OT services increased nationwide from $1.1B to $1.6B from 2009-21 which represents a 37 percent increase; however, this was driven by a 48% increase in patient volume, not the number of services per beneficiary which actually dropped by 6.9% during this time. Given that the rural population in the U.S. has declined from nearly 59.5 million to 56.8 million during this time[5], downward pressures on reimbursement cannot be addressed by increased patient volume, which would be difficult to achieve anyway given decreases in applications for OT programs, OTA reimbursement cuts and other factors.

Recommendation:
Permanently halt the implementation of the G2211 add-on code. The G2211 add-on code is a significantly flawed code that was created by CMS outside of the usual valuation process. When first introduced, the Medicare Payment Advisory Commission did not support the creation of this code as the different levels of E/M codes take into consideration the complexity of the beneficiary's condition, and additional code sets, such as the chronic care management codes, have since been implemented, which allow payment for primary care work that was previously unrecognized. Implementing G2211 will penalize clinicians who do not, or cannot, use it with yet another budget-neutrality-related reduction to the CF. The payment disparity for therapy services, compared to other healthcare providers, has grown significantly since 2022. Permanently halting the implementation of the G2211 add-on code will help to stop the ongoing reductions to payment for therapy services.

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[5] U.S. Rural Population 1960-2023. www.macrotrends.net. Retrieved 2023-10-05.

***Question - Health Care Workforce**: The Committee is requesting comments on policies to revitalize the health care workforce across the country to improve patient access to care, especially in rural and underserved areas. This includes policies that develop new providers and specialties in areas of the country where shortages are most acute, encourage providers to spend more time on patient care than paperwork, and ensure independent practice remains a viable option in a highly consolidated health marketplace. Comments should address existing barriers that prevent health care professionals at all levels from best providing health care services for patients. Feedback is also requested on how policies like nursing home staffing mandates at the state or federal level impact the health care workforce availability in other settings of care and the adequacy of how graduate medical education (GME) slots are being distributed in rural America.*

Mental Health Access in Rural Areas

There is a documented shortage of mental health professionals in America, and this shortage is much greater in rural areas. The profession of occupational therapy began more than a century ago in mental health treatment settings, and it remained an integral part of the interdisciplinary mental health team for decades. The number of occupational therapy practitioners working with those with mental and behavioral health disorders has declined, and OT services in community-based mental and behavioral health settings are particularly limited. The focus of occupational therapy is on the promotion of functional skills and independence, regardless of diagnosis, a skill set greatly impacted by mental illness and substance use disorder.

Recommendation:

Include language from the Occupational Therapy Mental Health Parity Act (S. 1592) in any upcoming workforce or mental health legislation. The *OT in Mental Health Parity Act* seeks to remove barriers to the provision of occupational therapy services for someone with a mental health diagnosis under Medicare where these services are already an allowed benefit. This would help Medicare beneficiaries more readily access occupational therapy services for behavioral health challenges impacting functional skills and help address the current shortage of behavioral health professionals. This language was included in a draft bill to improve the mental health workforce put forward by the Senate Finance Committee in the last Congress. It would simply require CMS to provide education and outreach to stakeholders that occupational therapy services can be furnished to individuals under the Medicare program for the treatment of a substance use or mental health disorder diagnosis using the OT Healthcare Common Procedure Coding System (HCPCS) codes. It should have no impact on the federal budget.

Access to Home Health OT Services in Rural Areas

Rural Americans face unique healthcare access issues, and these are especially challenging in home health settings where long distances between patient and provider are routine with OTs often required to drive between 100-200 miles a day to visit clients. In addition, home health agencies that serve rural populations generally have fewer therapists available, and this can cause service delays related to scheduling issues.

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.

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 in rural areas which usually have fewer nurses/therapists on staff. 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 does not take into consideration potential savings to the Medicare program related to avoided hospitalizations through the provision of OT services in the home resulting in fewer falls and other incidents. 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].

Question - Innovative Models and Technology: *The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas. Comments should address proposals that can be replicated at the federal level while ensuring providers with limited resources can participate. Feedback is also requested on how recent Medicare flexibilities may have bolstered access to care. Thought should be given to addressing how these policies can maintain and not diminish quality of care or increase overall costs to taxpayers.*

Innovative Programs to Improve Health and Quality of Life

Many innovative programs have been developed that focus on preventative health care and quality of life. Without a pathway for reimbursement, however, these programs are only available through grants and demonstration projects. In the field of occupational therapy, there is particularly strong evidence for programs that help people to age in place, both through the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) model, and other low-cost high-impact, OT-lead home modification programs such as those provided through HUD's Older Adults Home Modification Grant Program. OTPs also play a distinct role in helping those with Alzheimer's and dementia and their caregivers to optimize quality of life. A crucial component of supporting meaningful engagement for a person with dementia is supporting and training the caregiver as well as promoting caregiver wellness which is the focus of two evidence-based programs -- Skills²Care© and COPE. While these programs are supported by the Administration on Aging and some state Medicaid programs, there is currently no pathway to reimbursement for these interventions under Medicare.

Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to generate ideas on value-based care from the diverse provider community. The ability of the PTAC to approve smaller, innovative APMs is now more important than ever, as the Center for Medicare and

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[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

Medicaid Innovation (CMMI) has pledged to focus on fewer, larger alternative payment models. Despite the promise of the PTAC, 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. This program has demonstrated Medicare savings of $922 per beneficiary per month for at least 24 months after completion of the intervention due to a reduction in hospitalizations and other institutional based care. These types of interventions prevent people from entering the healthcare system thereby relieving some of the pressure on already overburdened rural healthcare systems.

Recommendation:

Congress should 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 has been 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 during the pilot to allow for more effective, broad-scale implementation.

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. These innovations have been especially beneficial to people in rural areas and to those for whom travel to receive services was already a barrier to access, including people with disabilities. This was demonstrated in a study on "*Trends in VA Telerehabilitation Patients and Encounters Over Time and by Rurality*" which concluded that "disparities between rural and urban veterans compel a mode of expanding delivery of care," and that "growth in telerehabilitation rural patient encounters increases access to rehabilitative care, reduces patient and caregiver travel burden and helps ensure treatment adherence."[10]

Among the most innovative OT services that was 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. This service 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.

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[10] Ibid p127

AOTA also notes that the CONNECT for Health Act (HR4189/S2016) was introduced to address myriad issues related to the continuation of telehealth in the overall healthcare system, 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.

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Thank you for your efforts to enhance healthcare in rural and medically underserved areas. 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