Rural and Underserved Communities Health Task Force Recommendations

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 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, while the impacts of illness, injury and disability are reduced.

Occupational therapy helps people participate as independently as possible in the necessary and desired activities that are a part of everyday life. Unlike other professions, occupational therapy helps people function in all of their environments (e.g., home, work, school, community) and addresses the physical, psychological, and cognitive aspects of health and performance. Through this expertise, occupational therapy practitioners have developed programs and interventions that address many issues of importance to this task force.

Among many skills, occupational therapy practitioners conduct home assessments to help ensure that beneficiaries can safely participate in the activities they consider most important. This is significant, as the Centers for Disease Control has identified occupational therapy led home modifications as the number one way to reduce costs associated with falls in the home.[1] Using a self-management approach, occupational therapy practitioners can help individuals to change their daily habits and routines to help better manage their chronic conditions, or to better manage pain. In addition, OTs work with people with dementia and their caregivers to focus on the person's remaining abilities, while also providing adaptations and modifications to help maintain participation for as long as possible. These interventions are most successful when provided in the home environment and are focused on maintaining health, not recovering from an acute illness or injury. As a result, their value is often not fully recognized within traditional payment methodologies. These challenges are exacerbated in rural areas, where low volume makes it even more difficult to implement innovative interventions.

We appreciate this opportunity to provide information and bi-partisan policy recommendations to the Rural and Underserved Communities Health Task Force as it reviews the delivery of healthcare in rural and underserved areas.

Question 3: What should the Committee consider with respect to patient volume adequacy in rural areas?

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 healthcare providers and professionals serving such areas. Long distances between patient and provider are of special concern to rural home health therapists who often drive from 100-200 miles per day visiting clients. In addition, home health agencies that serve rural populations

[1] https://doi.org/10.1016/j.amepre.2018.04.035

generally have fewer therapists available, and this can cause service delays related to scheduling issues.

CMS regulations currently prohibit occupational therapists (OTs) from opening home health therapy cases. This can cause delays for Medicare home health providers which are required to conduct an initial patient evaluation within 48 hours and a comprehensive evaluation within 5 days of receiving the home health order. The likelihood and impact of such delays are magnified for rural patients given the distances involved and number of home health therapists available. Additionally, OT may be the most appropriate discipline to perform that critical first home visit to evaluate the patient's environment to enable them to safely function at home.

The bi-partisan Medicare Home Health Flexibility Act (HR3127/S1725) would eliminate this restriction for therapy cases (where skilled nursing is not required). It is non-controversial having been endorsed by the American Speech-Language-Hearing Association (ASHA), the American Physical Therapy Association (APTA) and the National Association of Home Care and Hospice (NAHC). Passage would help ensure a safer transition between facility and home, and reduce the likelihood that services could be delayed, especially in rural/underserved areas.

Question 5: If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist.

The ability to provide OT services via telehealth would greatly benefit those who live in rural or underserved areas where access to in-person therapy service is limited. The U.S Veterans Administration (VA) is a leading innovator in this area, with a 2014 study reporting that 36% of occupational therapists in VA departments were providing OT services via telehealth.[2] In 2017, the VA reported that its occupational therapy practitioners had treated more than 403,000 unique patients, accounting for more than 1.5 million total encounters, and that 3,500 visits were conducted via telehealth that year.[3] The absence of restrictions related to the VA providing telehealth services across state lines has been of critical importance to maximizing the number of rural patients who can benefit from such services.

Another study 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."[4]

AOTA supports efforts to adopt legislation that would allow Medicare Advantage plans to provide OT services via telehealth. In addition, AOTA has endorsed the CONNECT for Health Act (H.R.4932/S.2741) that would allow providers to seek a waiver to provide OT (and other

[2] Voydetich, Deborah et al(2019)"Integration of Department of Veterans Affairs Telehealth into Occupational Therapy Practice" Department of Veterans Affairs

[3] Cowper-Ripley, Diane C et al "Trends in VA Telerehabilitation Patients and Encounters Over Time and by Rurality." *Federal practitioner: for the health care professionals of the VA, DoD, and* PHS vol36, 3 (2019): 122-128.

[4] Ibid p127

therapy) services via telehealth for Medicare patients. Passage of H.R4932 would benefit all Medicare beneficiaries, but especially those in rural areas where increased access is most needed.

Question 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?

Congress implemented the Excellence in Mental Health Act, and eight states currently participate in a resulting demonstration program that delivers intensive community-based mental health and addiction treatment services through Certified Community Behavioral Health Clinics (CCBHCs). To date, the program has demonstrated remarkable declines in ER utilization and significantly expanded access to behavioral health care in rural and underserved communities.

Occupational therapy helps people with behavioral health disorders learn the skills they need to live independently in the community. However, inconsistent reimbursement for OT behavioral health services under state Medicaid systems, and the overall lower reimbursement rate for mental health services, have become barriers to OTs providing these services, especially in rural areas. SAMHSA identified "licensed occupational therapists" as part of the suggested staff to be considered for inclusion in CCBHCs, and this inclusion has allowed for the successful recruitment and retention of OTs providing behavioral health services in rural Nevada and Oklahoma.

Even after the success of this eight state demonstration program; however, the future of CCBHCs remains in doubt. The Excellence in Mental Health and Addiction Treatment Expansion Act (HR 1767) would extend the existing demonstration programs, and expand the program to additional states that have already completed the CCHBC planning process. Other legislation, the Mental Health Professionals Workforce Shortage Loan Repayment Act (HR2431/S2500), would help increase access to behavioral health professionals in rural areas by providing loan forgiveness to those professionals, including OTs, who work in underserved areas.

Question 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?

Many local agencies on aging have put in place community programs to help address care delivery challenges in rural areas. Community partners such as Meals on Wheels and Habitat for Humanity are helping to try to better address long-term-health issues in the community. As mentioned in the introduction, occupational therapy practitioners have the skills and expertise to address many challenges including aging in place, managing chronic conditions and pain management and have partnered with these types of organizations. However, when pairing with community partners, confusion still exists about OT's role in these community systems which are outside of traditional health care settings, making these programs difficult to replicate in other locations.

Some occupational therapy practitioners have created programs where they provide these innovative services in the home through Medicare Part B. However, reimbursement for Part B services in the home do not take into consideration travel time, making reimbursement levels so low, the programs are difficult to maintain. Given long travel times, this problem is exacerbated in rural areas where such services are in *most* need. Additionally, the 2020 Physician Fee Schedule outlined a plan for 2021 **where Part B therapy services could be cut by an estimated 8%.** If this cut is implemented, none of these programs providing Part B services in the home will be sustainable, and many traditional outpatient clinics will struggle to stay open

Finally, while many home health agencies have been able to overcome the geographic and volume challenges of providing care in rural areas, the new Medicare Patient-Driven Groupings Model (PDGM) payment system, may create new challenges. AOTA supports the intention of PDGM in trying to better align payments with beneficiary needs, however we are afraid the new system will result in decreased therapy staffing levels, particularly in rural areas. For this reason, we believe it is now more crucial than ever that occupational therapists be able to open the home health case (H.R.3127).

Question 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?

1. AOTA recommends that the Ways and Means/Energy and Commerce Committees review and pass the Medicare Home Health Flexibility Act (H.R.3127) to streamline the process required to open home health therapy cases. This would be beneficial to all Medicare home health patients, but would be most helpful for those in rural areas given the distances driven to serve such patients by therapists working for small home health agencies.

2. AOTA also supports current efforts to introduce and adopt legislation in the House that would allow Medicare Advantage (MA) plans to provide OT services via telehealth. Therapy services were not explicitly included in legislation to expand telehealth services under MA in the last Congress. Further, AOTA recommends that the Committees review and adopt the CONNECT for Health Act (H.R.4932) that would allow providers to seek a waiver to provide OT (and other therapy) services via telehealth for Medicare patients.

3. In order to improve access to innovative, home-based services, AOTA supports including a consideration for travel time in the reimbursement for Medicare Part B Services provided in the home. Furthermore, Congress should ask CMS to consider the effect of its proposed 8% reduction in therapy payments on rural beneficiaries' access to therapy services.

4. Support HR 1767, the Excellence in Mental Health and Addiction Treatment Expansion Act, and HR 243, the Mental Health Professionals Workforce Shortage Loan Repayment Act, in order to help expand access to behavioral health services in rural areas.

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Thank you again for the opportunity to provide information and recommendations to the Rural and Underserved Communities Health Task Force as it reviews the delivery of healthcare in rural and underserved areas. If you have any questions about our comments or need additional information, you may reach me at 240-482-4137.

Sincerely,

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