Under the comprehensive outpatient rehabilitation facility provision, occupational therapy will now be covered in freestanding outpatient settings that meet the requirements for this new class of providers. Formerly, outpatient coverage was restricted to hospital outpatient clinics and, under rigid supervision requirements, physicians' offices. To qualify as a comprehensive outpatient rehabilitation facility, an institution must be primarily engaged in providing rehabilitation services to outpatients; offer, at the minimum, physician services, physical therapy, and psychological or social services; have policies established by a group of professional personnel; ensure that all patients are under the care of a physician; have in effect an overall plan and budget and a utilization review procedure; meet all state or local licensing requirements, where applicable, as well as any other conditions established by the Secretary of the Department of Health and Human Services for health and safety purposes.

The enactment of these amendments expanding reimbursement for occupational therapy culminated 15 years of effort by the AOTA, occupational therapists throughout the country, and members of Congress who understood and supported the need for improving access to this service in the outpatient and home settings. Medicare coverage of occupational therapy had changed very little since enactment of the law (P.L. 89-97) in July 1965. Basically, that coverage, as summarized in The American Journal of Occupational Therapy (February 1974), emphasized inpatient, institutional care and permitted only the minimum reimbursement for outpatient occupational therapy, and then only when furnished under extremely restrictive conditions.

One of the first calls for extending outpatient Medicare coverage came in December 1968 when the former Department of Health, Education and Welfare (DHEW) submitted a report to Congress entitled Independent Practitioners Under Medicare. That report noted that "the professions with the greatest potential for meeting the restorative needs of beneficiaries were clinical psychology, occupational therapy, physical therapy, social work and speech pathology." Among these services only physical therapy was already covered in essentially all outpatient settings. The report, therefore, recommended that Medicare be amended to permit similar coverage for these other services, including occupational therapy.

The next major revision to the Medicare law, following publication of the DHEW report, came in 1972 with the enactment of P.L. 92-603. This legislation, which began in the House of Representatives as H.R. 1, contained a plethora of omnibus Medicare reforms. When the legislative package was first developed in the House, there was no language that would permit expanded coverage of occupational therapy. In the course of the Senate's deliberations, legislative language was developed and incorporated into a floor amendment introduced by former Senator Adlai E. Stevenson (D-IL). Although the Senate adopted the Stevenson amendment as part of H.R. 1, support for the occupational therapy provisions was not strong enough to ensure their acceptance by the House-
Senate Conference Committee. The occupational therapy amendments were discarded during conference, and P.L. 92-603 was enacted with no change in the occupational therapy coverage.

The language of the Stevenson amendment, however, became the substance of several legislative proposals that were introduced and reintroduced over the next 6 years. This legislation, which was contained in one Senate bill with five cosponsors, two Senate Finance Committee amendments, and eight House bills with more than 125 cosponsors, included coverage for occupational therapy as a primary home health service and eight House bills with more than 125 cosponsors, included coverage for occupational therapy as a primary home health service and, when provided as an outpatient service in clinics, rehabilitation agencies and public health agencies.

In the fall of 1973, Senator Lloyd Bentsen (D-TX), calling the restrictions on occupational therapy coverage "unfair and unrealistic" (Congressional Record for October 3, 1973), offered the occupational therapy amendments as an amendment to H.R. 3153, another omnibus bill recommending several changes in the Social Security Act, of which Medicare is Title XVIII. Although the Senate accepted the Bentsen proposal and H.R. 3153 as amended, the legislation never went to a conference with the House.

The close of the first session of the 94th Congress, in the fall of 1975, marked another disappointing landmark for the occupational therapy amendments. Legislation (H.R. 10284) had been adopted by the House to make some technical Medicare adjustments that required approval before December 31 of that year. When the legislation was considered by the Senate Finance Committee, several amendments were added, including the occupational therapy proposals as introduced by former Senator Gaylord Nelson (D-WI). Other pending business delayed the legislation's return to the House until mid-December, just days before the end of the session.

Normally, H.R. 10284 would have been the subject of a House-Senate conference to settle the differences between the two versions of the bill. The need for action on the bill's original provisions and the imminent end of the session prompted use of another procedure. The bill was taken directly to the House floor under a "unanimous consent" rule. This rule provides that the legislation under consideration can only pass if no one objects to it. Immediate objections were voiced by several Representatives, mostly Republicans, who felt the Democratic leadership was too hasty in its efforts to force through legislation the Senate had made into a "Christmas tree" by adding many pet provisions the House had not considered. One by one the objections were removed until only one remained, and prevailed, that of the Republican Minority's "procedural watchdog," former Rep. Robert Bauman (R-MD), who stated before his colleagues: "I value my oath of office too much to be a party to this irresponsible parliamentary procedure" (Congressional Record of December 18, 1975, H 12983).

With the failure of the unanimous consent, the Democratic Majority agreed to remove all amendments that were either controversial or had not been previously considered by the House. The occupational therapy amendments failed the second test and thus were absent from H.R. 10284 when it passed the House on a straight vote the next day, December 19, 1975.

The next year saw little Medicare legislative action. Occupational therapists throughout the country, however, were becoming more increasingly involved in efforts to gain support for the occupational therapy amendments. Working closely with the American Occupational Therapy Association staff, Association members went directly to their Representatives and Senators, urging the importance of these proposals. These efforts resulted in the introduction of several bills during 1976 and early 1977, the beginning of the 95th Congress.

House legislation was introduced by former Representatives William F. Walsh (R-NY), Donald P. Clancy (R-OH), and Martha Keys (D-KS), and by current Representatives J. J. Pickle (D-TX) and John Duncan (R-TN).

The 95th Congress also saw the emergence of a major champion of the need for improved access to occupational therapy services. Early in the First Session, Representative Lindy (Mrs. Hale) Boggs (D-LA) began to work actively for inclusion of the occupational therapy amendments in the next major Medicare reform. Her efforts were focused around legislation (H.R. 9826) she introduced together with 42 House colleagues. Mrs. Boggs noted in her remarks accompanying the legislation that the "equitable treatment of our elderly and disabled people, for whom the (occupational therapy) Medicare benefits are intended, requires the enactment of this legislation" (Congressional Record for October 31, 1977 at E6705). Citing a report of the Health Insurance Association of America (HIAA) in support of the cost savings proper coverage of occupational therapy could produce, Mrs. Boggs noted that "in view of the alarming increase in health care costs in recent years, we should consider carefully these recommendations of the private insurance industry and support coverage for services such as occupational therapy, which have proven to be cost-effective as well as medically beneficial" (Congress-
ional Record October 31, 1977, E6705).

By early summer of 1978, the Health Subcommittee of the House Committee on Ways and Means had assembled a package of omnibus Medicare benefit amendments that was the first of its kind since 1972. The scope of these Medicare reforms was severely restricted by the growing consciousness, within the Congress, of a need for cost restraints in the health care area. When the package formally came before the Subcommittee, a $100 million limit had been placed on the proposed legislation. Although the occupational therapy home health amendment was included in the draft, the outpatient proposal was not. The cost estimate for the home health section, moreover, as developed by DHHS, was an unrealistically high figure of $28 million.

The cost estimate for the home health amendment combined with the $100 million limit on the total package both worked to the detriment of occupational therapy. The Subcommittee's deliberations were conducted under an agreement that, if any additional amendments were added to the original draft, a parallel provision of equal cost would have to be removed. Just such an amendment, one affecting coverage of chiropractic services with a cost estimate of $24 million, was proposed by former Representative James Corman (D-CA). For many years, Mr. Corman had been an ardent advocate of the chiropractor provision and his standing on the Subcommittee was sufficient for his proposal to prevail by a 5:4 vote.

Although the final legislation introduced by the Subcommittee (H.R. 13097) did not contain the occupational therapy home health provision, it did include an amendment, sponsored by former Representative Omar Burleson (D-TX), which established comprehensive outpatient rehabilitation facilities as Medicare Part B providers. Occupational therapy was to be a major service provided by these facilities and, in fact, this provision represented the bulk of the outpatient occupational therapy amendment contained in the Boggs legislation.

As H.R. 13097 was prepared for consideration by the full Ways and Means Committee, efforts were continued to gain support for reinsertion of the home health amendment. Once again occupational therapy found an articulate and forceful spokesman in the person of Representative Charles Rangel (D-NY). Through contacts made by therapists in his home district, Mr. Rangel had been alerted to the importance of occupational therapy for the elderly and disabled. He agreed then to sponsor reinsertion of the home health provision during the Committee's consideration of H.R. 13097. Mr. Rangel's leadership provided the catalyst for an unexpected mushrooming of support for the occupational therapy provision. An initial vote of 16:11 in favor of reinsertion was rejected for lack of a quorum. Unfortunately, the subsequent vote, a 15:15 tie, fell one short of the majority required for adoption of the home health amendment. Adding to the chagrin of the supporters of the occupational therapy proposal was the fact that a tie-breaking proxy vote in their favor was not cast because of a mixup in communications among Committee members.

Although H.R. 13097 was overwhelmingly accepted by the House without the occupational therapy home health proposal, one last piece of drama still remained in the 95th Congress. The Senate had a series of bills that roughly paralleled the content of H.R. 13097. In both houses, moreover, the Medicare legislation was closely intertwined with controversial efforts to impose cost containment limits on hospital expenditures. As the 95th Congress wound down amidst a closing 5-day marathon session in mid-October, the only hope for adoption of any Medicare legislation resided in efforts to separate the Medicare proposals from the most controversial parts of the cost containment issue.

On the next to last day of the 95th Congress, a plan was ready to adopt Medicare amendment legislation, which then could be considered by both houses together with H.R. 13097. Former Senator Herman Talmadge (D-GA) had agreed to include the occupational therapy home health provision in the Senate package. Extraneous events, however, foiled adoption of the ill-fated Medicare provisions, because a 14-hour filibuster on a proposed energy bill absorbed the Senate's attention to the point where no time remained for consideration of the Medicare proposals. The 95th Congress adjourned with the Medicare law unchanged.

The 96th Congress convened in January 1979 with some optimism that action on Medicare reform might succeed. Although the concern over health care costs continued to grow, an attitude of support for the Medicare proposals developed during the last Congress was also present.

On the House side, Representative Rangel, the new Chairman of the Ways and Means Subcommittee, initiated early action on the provisions contained in the former H.R. 13097—which had been reintroduced as H.R. 3990. Rep. Boggs, likewise, reintroduced the occupational therapy amendments (H.R. 4063) together with more than 50 cosponsors. Both Mrs. Boggs and Mae Hightower-Vandamm, AOTA President, testified in support of the occupational therapy amendments during the
The amended version of H.R. 3990 had a cost limit of approximately $150 million. The new limit permitted reintroduction of the occupational therapy home health provision, again strongly supported by Chairman Rangel, without reoccurrence of the need for any trade-off with the chiropractic amendment. Under these conditions Rep. Corman fully supported the occupational therapy home health provision. H.R. 3990, which now included both the comprehensive outpatient rehabilitation facility provision and the occupational therapy home health amendment, as well as another amendment that would have favorably affected occupational therapy by establishing community mental health centers as Medicare providers, easily won the approval of the full Ways and Means Committee.

Since H.R. 3990, when first introduced, was also referred to the Committee on Interstate and Foreign Commerce, approval by this second Committee was required before the bill could go to the House Floor. The Commerce Committee’s deliberations were marked by a determined, but unsuccessful, attempt to strip H.R. 3990 of all its home health provisions, including the occupational therapy amendment. An effort was also made to limit the types of professionals to the exclusion of occupational therapists, who could provide Medicare covered services in community mental health centers. This attempt also was ultimately blocked and, by late spring 1980, H.R. 3990 and a companion bill, H.R. 4000, which included amendments to the Professional Standards Review Organization and Medicaid laws, were ready for consideration by the full House.

Development of Medicare legislation in the Senate during the 96th Congress took a somewhat different form. The action centered almost exclusively in the Senate Finance Committee. Early in the first session, two bills (S.505 and S.507), containing some few benefit amendments and extensive administrative and reimbursement reforms, were introduced. Neither bill included the occupational therapy proposals, although other legislation (S.489) dealing primarily with home health reform did contain the occupational therapy home health provision.

Throughout the major part of the 96th Congress, the Finance Committee’s health discussions focused primarily on the global issues of national health insurance, administrative reform, and fraud and abuse within the current system. Concern for the spiraling increase of health care costs and the development of effective and acceptable means of cost containment pervaded the deliberations. Specific benefit expansion proposals emerged only in random and periodic fashion.

The interest of several Senators in home health reform did spark a hearing before the Committee’s Health Subcommittee in the spring of 1979. During the hearings, Senators Robert Dole (R-KS), Lawton Chiles (D-FL), Patrick Leahy (D-VT), and Pete Domenici (R-NM), and several other witnesses testified in favor of the occupational therapy provision. Two witnesses, one of whom was unfamiliar with occupational therapy, did not feel the amendment was necessary. The position of the other witness, who testified on behalf of the National League for Nursing, was later reversed by the League to one of support. The AOTA also provided testimony for the record.

By spring 1980, the Finance Committee’s Medicare package was in final form and attached to a minor tax relief bill (H.R. 934) passed earlier by the House. H.R. 934 contained many of the Committee’s administrative reform provisions and some benefit expansion. Of the benefit amendments that would affect occupational therapy, however, only the comprehensive outpatient rehabilitation facility proposal was included. For tactical reasons, H.R. 934, as amended and reported by the Committee, was not taken to the floor for a full Senate vote.

Ordinarily, the health care legislation developed by both houses would have culminated in a House-Senate Conference on the provisions contained in H.R. 3990, H.R. 4000, and H.R. 934 as amended. A comprehensive congressional budget-cutting initiative, however, had begun in early January 1980. Spurred by rising inflation and the growing support for reducing government spending, the Budget Committees in both houses commenced a process whereby the Congress as a whole would review substantive programs to reduce spending and increase revenues in an all-out effort to secure a balanced budget. This was the process, never before used, known as “reconciliation.” Its initiation and ultimate conclusion dramatically revised the future course of the Medicare legislation.

From the start, budget reconciliation was a controversial issue, since it shifted the balance of power away from authorizing committees with jurisdiction over specific programs and toward the respective budget committees. Overall budget reductions were developed by the Budget Committees, which then in turn assigned specific dollar savings to each of the authorizing committees. The method for attaining targeted savings was left to the discretion of each committee. Although many feathers were ruffled by what was widely considered an inappro-
appropriate infringement of the authority of authorizing committees, the national unrest over the state of the economy aroused sufficient congressional support to continue the process.

The all-encompassing attention both houses paid to budget reconciliation seemed at first to doom any further consideration of Medicare benefit legislation. The Senate Finance Committee stripped all spending provisions from its reconciliation proposals. In the House, however, a different tack was taken. Supporters of the Medicare legislation, especially Mr. Rangel and Representative Henry Waxman (D-CA), agreed that the mix of savings and spending contained in the Medicare-Medicaid package (H.R. 3990 and H.R. 4000) could appropriately be included in the reconciliation legislation, since the net result of the Ways and Means Committee recommendations met the targeted savings established by the House Budget Committee. Although the inclusion of spending provisions within a budget reconciliation bill met expected opposition at every step in the House process, the supporters of the Medicare-Medicaid provisions prevailed, and the amendments were included in the legislation (H.R. 7765) finally adopted by the full House.

By early fall 1980, the scene was set for the final scenario, the House-Senate Conference on the two versions of budget reconciliation legislation. The two bills contained measures within the jurisdiction of all Senate and House Committees, and, as a result, an extraordinary number of more than 100 conferees were appointed to the Conference Committee. To facilitate action, however, only conferees from parallel committees, together with Budget Committee representatives, negotiated the issues related to their respective jurisdictions.

From the outset, it was clear that reaching a consensus on the issues assigned to the Ways and Means/Finance Conference would not be an easy matter. Numerous substantive and significant differences existed in the two committees' versions of their sections of the reconciliation bill. There was, moreover, a serious question of time or, more correctly, the lack thereof. The month was September. Congress was scheduled to recess, if not finally adjourn, in early October to permit members to campaign for the upcoming November election. Many observers believed that "reconciliation" was dead.

For occupational therapists and others affected by the Medicare spending provisions in the House bill, there was serious concern whether the Senate conferees would be willing to accept the House provisions. Of those amendments affecting occupational therapy, the rehabilitation facility proposal seemed to stand the best chance for acceptance since it was contained in the Finance Committee's version of H.R. 934. No similar action, however, had been taken on the home health or community mental health center provisions during the 96th Congress. Extensive efforts were made by therapists throughout the country, as well as by Representatives Boggs, Rangel, Butler Derrick (D-SC), and other House members, to gain support for the occupational therapy provisions, especially that affecting home health coverage.

Hope for success of the home health amendment was significantly strengthened when Senator Russell Long (D-LA), Chairman of the Finance Committee, agreed to support its inclusion. Senator Long's position won the approval of the other Senate conferees and both the occupational therapy home health and the rehabilitation facility provisions were among the items accepted by the Conference Committee before its recess in early October.

As decided at the time of its recess, Congress reconvened in early November after the elections. Even though the conferees had reached agreement on numerous issues, the ultimate fate of the reconciliation legislation still remained very much in doubt.

The outcome of the elections did nothing to assuage fears that the reconciliation bill would fail. A new administration had been chosen, the majority in the Senate had shifted from Democrat to Republican, the Democratic majority in the House had been seriously weakened, and the many "lamed" and "disabled" who would return for the upcoming "lame duck" session could not necessarily be expected to renew vigorously the painstaking negotiations required to complete the reconciliation process.

In the end, however, the months of work already committed to reconciliation overrode whatever inclination existed to let the process fail. Within a few short weeks, a final consensus was reached by the Ways and Means and Finance conferees. Similar agreement emerged from the other mini-conferences, and, in summary fashion, this massive legislative package (H.R. 77) passed both houses.

By early December, the "Omnibus Reconciliation Act of 1980" sat on President Jimmy Carter's desk awaiting his signature. The Act contained both the outpatient rehabilitation facility and the occupational therapy home health provisions. On December 5, 1980, P.L. 96-499 came into existence.