



**STATEMENT OF THE  
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION  
SUBMITTED TO THE SUBCOMMITTEE ON HEALTH,  
U.S. HOUSE OF REPRESENTATIVES COMMITTEE  
ON WAYS AND MEANS  
FOR THE HEARING  
“Post-Acute Care”  
June 16, 2005**

The American Occupational Therapy Association (AOTA) represents nearly 35,000 occupational therapists, occupational therapy assistants, and students of occupational therapy to promote the interests of the profession and patients. AOTA submits this statement for the record of the hearing on June 16, 2005 on the current financing and assessment of post-acute Medicare providers. Occupational therapists and therapy assistants work in post-acute care settings to increase the independence and quality of life of their patients.

Occupational therapy practitioners provide services in a variety of settings, including, long term acute care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and in the home (HHA). Occupational therapy is a health, wellness, and rehabilitation profession working with people experiencing stroke, spinal cord injuries, cancer, congenital conditions, developmental delay, joint replacements and surgeries, mental illness, and other conditions. It helps people regain, develop, and build skills that are essential for independent functioning, health, and well-being.

AOTA strongly supports maintenance of the full spectrum of post-acute care settings to assure that patients have choice, that health care dollars are used most efficiently, and that the best possible outcomes are achieved. With that said, AOTA also supports efforts to develop more consistent and comprehensive methods to determine patient needs for post-acute care and continuing research on best practices and protocols.

Occupational therapy professionals assist those with traumatic injuries—young and old alike—to return to active, satisfying lives by showing survivors new ways to perform activities of daily living, including how to dress, eat, bathe, cook, do laundry, drive, and work. It helps older people with problems like stroke, arthritis, hip fractures and replacements, and cognitive problems like dementia. In addition, occupational therapists work with individuals with chronic disabilities including mental retardation, cerebral palsy, and mental illness to assist them to live productive lives. By providing strategies for doing work and home tasks, maintaining mobility, and continuing self-care, occupational therapy professionals can improve quality of life, speed healing, reduce the chance of further injury, and promote productivity and community participation for Medicare beneficiaries.

Medicare provides health insurance for nearly 35 million people over 65 years old and 6 million people under 65 years old with permanent disabilities. Medicare benefits are expected to total \$325 billion in 2005, accounting for 13% of the federal budget. In post-acute care settings, Medicare expenditures are currently more than \$30 billion annually. It is critical for Congress to determine whether patients are being treated in the most appropriate post-acute care setting and whether



Medicare dollars are being allocated appropriately. LTCHs, SNFs, IRFs, and HHAs have all experienced major changes over the past 10 years.

The multiple and ongoing changes to Medicare post-acute care payment policies creates a unique environment in which measuring the effect of service delivery is particularly difficult. One of the biggest changes is the implementation of new prospective payment systems (PPS) for each post-acute care setting. Each PPS varies in terms of key design features such as the unit of payment (per diem, per discharge, every 60 days), classification schemes (RUGs, HHRGs, and case mix groups), and patient assessment instruments and processes used for patient classification (MDS, OASIS, and IRF-PAI). Each of these payment systems were installed on different timetables, and each is being modified in different ways and at different times. Such fragmentation could affect the quality and outcomes of patients in post-acute care.

The policy concern that Medicare may be paying different amounts to different types of post-acute care providers for patients with similar care needs raises important questions for AOTA. How are we judging effectiveness? Have post-acute care providers worked to achieve the highest functional outcomes possible for its beneficiaries? What are the prospects and problems for moving ahead with a standardized assessment tool to evaluate the level of care a patient requires in each post-acute care setting? Will we create a system that does not have enough variation in options to achieve optimum goals for patients?

The focus of post-acute care includes medical stabilization as well as practical improvements in function, with discharge determined by the speed in which the person returns to a reasonable level of independence. Occupational therapists and therapy assistants work in different post-acute care settings providing varying intensities of therapy to best meet the needs of their patients.

Occupational therapy services are considered reasonable and necessary when it is expected that the therapy will result in significant improvement in the patient's level of function within a reasonable amount of time. With speedy discharge to return to normal activities an important aspect of post-acute care, function should be the governing assessment component across all settings. Where will the patient best regain medical stability but also regain ability to fully recover and return to activities? Occupational therapy is not only focused on lost function, but also improves a patient's ability to remain independent and sense of well-being which can contribute to better recovery following post-acute care. It is imperative that occupational therapy be an integral part of the development of the plan of care of people transitioning into post-acute care, in determining readiness for discharge and in developing discharge plans. Occupational therapists' and therapy assistant's success can be measured by the quality of life and level of independence of their patients once they are discharged. This should also be the measure of the effectiveness of Medicare dollars.

Each post-acute setting provides different levels of therapeutic intervention combined with differing levels of other care. Each setting has advantages for different types of patients. However, each post-acute care setting uses a different patient assessment instrument to evaluate the level of care a patient requires. This makes it difficult to know whether patients are being treated in the most appropriate setting and whether Medicare dollars are being allocated appropriately. Any standardized assessment should look at the distinct aspects and benefits of the services provided in that setting. A standardized assessment would need to focus on the differences in each post-acute care setting and



the services provided there. A standardized assessment should also recognize the distinct differences and contributions of each needed service.

One significant problem faced by occupational therapists in post-acute care settings is the financial limitations on therapy imposed by Congress in the Balanced Budget Act of 1997. The legislation imposed a \$1500 annual cap on Medicare Part B outpatient occupational therapy alone and physical therapy and speech-language pathology combined. A 2-year moratorium was included in the Medicare Modernization Act of 2003 (P.L. 108-173), however, that moratorium will expire on December 31, 2005. Congress currently has before them a piece of legislation that repeals these therapy caps. However, current discussions have included a number of different options on how to address this piece of bad policy. AOTA has stressed the need to keep occupational therapy distinct and separate because of the uniquely beneficial service that occupational therapists and therapy assistants provide. Financial limitations to proper therapy services impede the therapists' ability to care for their patients appropriately and use professional judgment effectively.

Another critical issue for occupational therapy is the limitation experienced by occupational therapy practitioners in home health field because of an outdated and obsolete eligibility criterion. Beneficiaries must need one of three qualifying services –nursing, physical therapy, speech-language pathology services—to be eligible for the full home health benefit. Occupational therapy cannot be an initial qualifying service. As far back as March 1997, the former Medicare Prospective Payment Commission said that the “lack of a clearly defined benefit compromises” the program’s ability to pay only for services that are reasonable, necessary and medically appropriate. AOTA believes that a key problem in the definition of the home health benefit is the qualifying service issue which may cause some patients to receive unnecessary physical therapy, for instance, when their need is for occupational therapy. The failure to recognize occupational therapy as an initial qualifying service limits the use of occupational therapy to conduct important activities including the initial OASIS. Legislative action is necessary to correct this; AOTA urges further study of how this could be changed in a cost effective manner.

Finally, AOTA commends the Subcommittee for taking the time to debate and learn more about the post-acute care system. Congress is in a position to create a system more tailored to the services required by patients rather a system that favors the setting in which patients are placed. AOTA looks forward to working with the Committee to better our nation’s healthcare system.

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