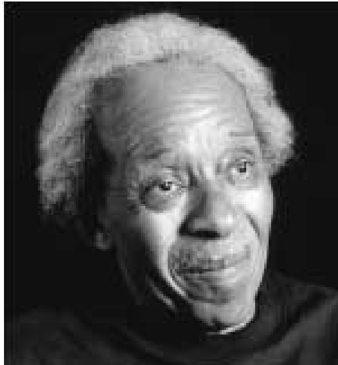
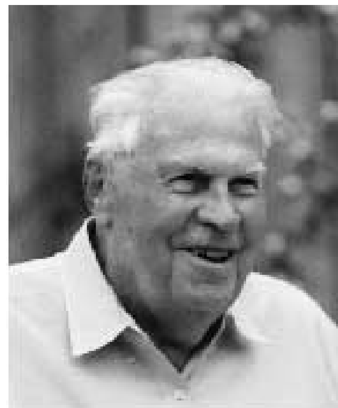


THERAPY CAP REPEAL

ACTION GUIDE



National Association for the
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$1500 Outpatient Therapy Caps Repeal Action Guide

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MEDICARE ACCESS TO REHABILITATION SERVICES ACT (H.R. 3834) / (S.1394)

HISTORY AND BACKGROUND

- Prior to enactment of the *Balanced Budget Act of 1997* (BBA), $900 annual Part B caps were **only** applied to physical therapists and occupational therapists in independent practice settings. In addition, payment to these providers under the Medicare program was made on a reasonable cost basis. There were no dollar limits for services provided in any other setting; i.e., skilled nursing facilities, etc.

- As a result of the BBA, many providers were shifted to a prospective payment system (PPS), and therapy service reimbursement was shifted to a fee schedule. In addition, amounts for the therapy caps were raised to $1500 annually for Part B. However, the caps applied to **all** settings except hospital outpatient departments. In addition, speech-language pathology services were combined with physical therapy under one cap. The caps were intended to be beneficiary caps; i.e., regardless of the provider, a beneficiary would only be provided Medicare Part B coverage up to $1500. Once a beneficiary exceeded the caps, the beneficiary would have had to pay 100 percent of the out-of-pocket costs.

- Responding to the BBA, then Representative Ensign and Senator Grassley introduced the *Reinstatement of the Medicare Rehabilitation Benefit Act of 1998* (H.R. 3835/ S. 2222) to repeal the $1500 Part B therapy caps. The bills garnered 109 and 12 congressional co-sponsors respectively.

- The following year, Representative Burr and Senator Grassley introduced the *Medicare Rehabilitation Benefit Improvement Act of 1999* (H.R. 1837 / S. 472) to establish specific exemptions to the $1500 Part B therapy caps. The bills attracted 127 and 57 co-sponsors respectively.

- As a result of the *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999* (BBRA), Congress placed a two-year moratorium on the Part B therapy caps until January 2002. In addition, the BBRA required focused medical reviews of claims for therapy reimbursement.

- Due to the difficulty of establishing an alternative payment methodology, provider and consumer groups pressed for a three-year moratorium extension. Ultimately, *the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA) extended the moratorium one more year until January 1, 2003.

- The *Medicare Access to Rehabilitation Service Act of 2002* (H.R. 3834 / S. 1394) is now under consideration to address this issue

MEDICARE ACCESS TO REHABILITATION SERVICES ACT (H.R. 3834) / (S.1394)

TALKING POINTS

- **Unless Congress acts, seniors will again face arbitrary limits on their rehabilitation therapy care.** On January 1, 2003, the Medicare outpatient beneficiary caps on rehabilitation therapy will take effect. These $1500 beneficiary caps on (1) occupational therapy and (2) physical and speech-language therapy care combined will negatively impact care for our nation's seniors. Since the caps were partially implemented in 1999, Congress has twice placed such implementation under a moratorium until the end of this year. It is time to repeal these arbitrary beneficiary caps once and for all!

- **Seniors will receive fewer services over time.** Not only were the Part B therapy caps arbitrary but they were not indexed to inflation.

- **Approximately 12-13% of seniors needing therapy care will exceed the annual Part B caps.** Both MedPAC and independent analysts have demonstrated that nearly one out of seven needing therapy care would exceed the beneficiary caps. If the caps are implemented, beneficiaries who reside in a skilled nursing facility may self-ration care or be forced to forgo medically necessary care once they have exceeded their annual caps, as ***consolidated billing denies them the opportunity to seek services from another provider***.

- **Therapy caps would negatively impact seniors who suffer from stroke or other circulatory-related ailments, Parkinson's disease, and musculoskeletal disorders.** One analysis conducted in 1999 on the impact of the Part B therapy caps during the first two months (based on actual Medicare claims) illustrated the following:

  - Of those who exceeded the $1500 Part B cap for **occupational therapy**, 46% were beneficiaries who suffered from stroke-related ailments and 23% were those who had osteoarthritis and related musculoskeletal disorders.

  - Of those who exceeded the $1500 Part B cap for **physical/speech-language therapy**, 43% were beneficiaries who suffered from both stroke- and heart-related circulatory ailments and 28% were those who had osteoarthritis and related musculoskeletal disorders.

- **Rehabilitation services play an integral role in addressing quality indicators that CMS uses to measure nursing home performance.** These quality indicators include such clinical needs as weight loss, dehydration, pressure ulcers, incontinence, and decline in activities of daily living. There is a need for adequate funds to allow therapists to assist in meeting these clinical needs.

- **It will be the older and more vulnerable beneficiaries who will be most affected by the Part B therapy caps.** As beneficiaries continue to age and encounter multiple health problems, they are more likely to be the ones to exceed the caps.

THE ABC's of LOBBYING

Prepared by Greenberg Traurig for NASL

A	B	C
• Always be polite • Always make your case relate to something that they are thinking about • Avoid information that is complicated or replete with initials or industry jargon • Allow interruptions • Acknowledge all questions as necessary and important • Ask for something • Acknowledge the meeting with a follow-up thank you	• Be careful to spend more of your time listening - it will surprise you how much you can learn • Be a constituent, tell a personal story • Brevity is appreciated; details are forgotten • Be certain to ask for something	• Check your facts; don't know an answer, get back another time • Courtesy counts • Call the staff person by their name • Check the clock - running overtime is not good

DELIVERING YOUR YOUR MESSAGE

- Acknowledge Congress is looking at Medicare issues
- State precisely **who** you are, **what** you are asking, and **why** it is important
- Tell a constituent or a senior program
- Ask for their feedback
- Thank them **PROFUSELY** for the meeting

The American Health Care Association's

HOW TO …
Put a Local Face on National Issues

You Have a Great Story to Tell

You are an integral part of your community because you care for local individuals, provide jobs to local men and women, make a contribution to the local economy and tax base, and provide an increasingly essential local community need - long term care for a growing aging population.

As a local business leader, whose efforts generate enormous benefits for your community, people will appreciate your participation in community affairs. Make the most of it! These activities can not only protect your ability to provide quality care, but also establish in the public mind the linkage between the long term care industry and the well being of the local community.

Community Involvement is the First Step

Just by getting to know national and state elected officials in the course of community, county, statewide and regional events, you make it less likely that they will target the long term care industry with burdensome legislation. Without a "human face" in mind, legislators are more apt to see our industry as a suitable target - or even an easy target.

How do you accomplish this personal contact? Just invest one or two hours a month in some form of community participation. This will gain recognition for you and for the long term care industry.

It will put that all-important "human face" on issues of vital importance to your facility and industry. For example, start by joining civic clubs such as the Jaycees or Chamber of Commerce. Make friends and become active. If you are already a member, volunteer more and take more of a leadership role. Any business organization that has a legislative committee is an excellent vehicle for promoting long term care financing issues.

You're the Expert
Elected Officials Need to Know What You Know

National and state legislators and other elected officials are just people. You can approach them with confidence. Their job is to listen to and represent their constituents. And constituents like you have valuable expert insight to offer.

Whenever you have access to a legislator, talk positively about the many ways your facility is caring for its residents and contributing to the community. Feel free to discuss issues you are concerned about as a long term care provider.

Don't just chat. Talk about the people to whom you provide services. Also, make it a priority to explain the potential positive or negative impact of pending legislation on your facility, your residents and staff..

IDEAS FOR Grassroots Activities

Provide information to Activities Directors/CTSRs of ALFs, CCRCs and short-term rehabs.

Information should include:

- Basic Medicare A versus Medicare B coverage information (including very brief PPS explanation)
- Therapy Caps Talking Points
- ABCs of Lobbying Sheet
- Congressional Contact Information
- Rehab contact to assist with questions/concerns

When speaking to local groups, include a very basic explanation of Medicare A and Medicare B benefits.

- Medicare A is for acute services (first care level - hospital and immediately after)
- SNF coverage for Medicare A is paid under a PPS system
    - Requires 5 full assessments within 100 days
    - Medicare has specific requirements that must be met for benefits to be paid
    - 100 days of coverage is not guaranteed
- Medicare B coverage is for the long-term care residents (when you do not have a hospital stay)
    - This is where the therapy caps hit hardest
    - When a beneficiary reaches the $1500 therapy cap for the year, he or she becomes responsible for 100% of therapy costs for services needed during the remainder of the year.

Community and Service Organizations to Contact

Kiwanis Chapter
Rotary Club
Lions Club
Church Groups (esp. Seniors groups within a church organization)
Civic Associations
Senior Centers
AARP Chapter
Knights of Columbus Chapter
B'nai Brith Chapter

CONGRESSIONAL FEEDBACK FORM

Meeting Date: ________________

Member of Congress: ____

Staff Person: ____

AEGIS Associate(s): ____

____

____

ISSUE

$1500 Outpatient Therapy Caps Repeal

Circle One: (*against*) 1 2 3 4 5 (*supportive*)

Comments:

The Impact of
Arbitrary Therapy Caps

Patient Case Studies

CVA (Stroke) Patient

Dysphagia Patient

Medically Complex Patient

Parkinson's Disease Patient

Wound Care Patient

Alzheimer's Patient

Patient Case Study 1

CVA (Stroke) Patient

BACKGROUND

Patient had a CVA (stroke) resulting in left-sided weakness early in the calendar year. He received 75 days Physical and Occupational Therapy at that time under Medicare Part A and was able to regain much of his physical functioning.

Patient then appeared to have multiple seizures while in the Nursing Facility, resulting in increased weakness and significantly decreased overall functioning. Patient is now unable to consistently hold himself up while sitting, cannot stand safely and is unable to walk independently. In addition, he cannot perform any Activities of Daily Living such as personal grooming, dressing, feeding and basic hygiene. Swallowing is severely impaired and patient must be fed via a feeding tube because he is very likely to choke on food that is fed orally. His Medicare Part A benefits were exhausted at this time and this was not considered a new spell of illness, despite the decreased functioning levels.

DISCUSSION OF TREATMENT

After a restricted course of treatment ($1500 caps as currently structured allowed for 10 sessions of Physical Therapy, 12 sessions of Speech and Swallowing Therapy and 22 sessions of Occupational Therapy), he was able to tolerate a diet that is blended to a baby-food consistency with thick liquids under strict supervision. He is only able to tolerate 25% of his meal so he must continue on tube feeding. Physically, he is able to walk short distances with a special walker and stand by assistance. He is also able to dress himself with minimal assistance using adaptive devices. His goal remains to return home with a live-in caregiver but is highly depressed at his physical and communication status. He will remain in the nursing home, unable to go to community events with friends and family. He will likely lose control over his personal business and finances.

Without the $1500 caps restriction on the intensity and duration of treatment, this patient had the potential to be discharged home at a fully independent level with adaptive devices. He would be able to complete basic home management and personal business. He could be on a general diet with thin liquid and no need for alternate nutrition or hydration. His quality of life would be greatly improved and he would be able to go to the local restaurant with friends for the Friday Fish Fry without the need for any diet modifications or other compensations.

Patient Case Study 2

Dysphagia Patient

BACKGROUND

A resident with dysphagia (a swallowing problem) who received only $1500 of speech-language pathology treatment receives a diet change incorporating a consistency of food that is chopped into fine pieces mechanically and thickened liquids. He learned a general compensatory technique (tucking his chin during the swallow to assist with keeping liquids in his mouth until he is ready to swallow) during swallowing treatment. While these changes met the resident's immediate needs, they did not necessarily reflect the resident's long-range needs.

DISCUSSION OF TREATMENT

Swallowing function could be restored through additional treatment, including such services as a longer course of strategic oral motor exercises aimed at increasing strength and range of motion of the oral musculature. Through a longer course of treatment, the resident could also learn a variety of individually tailored compensatory strategies that would allow a diet that does not need to be altered in any way. Longer treatment would afford an opportunity to attempt a variety of compensatory techniques that would allow identification of the safest method. It could be possible to eliminate thickened liquids or reduce the amount of thickener that is required. Additional treatment would also allow caregiver education with return demonstration to assure that safe swallowing strategies are utilized on a consistent basis in the dining room across all meals.

Patient Case Study 3

Medically Complex Patient

BACKGROUND

The geriatric patient admitted to rehab services in a skilled nursing facility for other than orthopedic or neurological rehabilitation typically fits the description of a "medically complex" patient. This individual will have several medical conditions affecting multiple body systems simultaneously with the result of severe overall debilitation, severe intolerance for physical activity, and the need for prolonged rehabilitation. This patient often will not have spent enough time in an acute care setting to qualify for Medicare Part A coverage. This patient may also be a long-term resident of the facility who does not go to the hospital for treatment of these conditions, instead receiving medical care in the skilled nursing facility itself. The diagnoses commonly suffered by these individuals are cardiac, circulatory, metabolic, and/or pulmonary, typically in combination. For instance: atrial fibrillation, congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and pneumonia. Medically complex patients will show deterioration in all aspects of daily living skills: dressing, feeding, bathing, and grooming. Severe declines will also occur in mobility skills, rolling, sitting, coming to stand, and walking. This patient will also typically show a decline in the ability to express his/her own needs, and intake enough calories and oxygen to sustain life. Most often, the causative factor for all of these problems is the patient's severely debilitated condition and inability to sustain prolonged activity in order to increase his/her activity tolerance.

DISCUSSION OF TREATMENT

The focus of the rehabilitation provided by all 3 therapy disciplines (Physical, Occupational and Speech-Language Therapy) is to teach the patient to work within his/her existing tolerance level, all the while, increasing in tolerable increments the workload of the patient. In physical therapy (PT) the patient would address the mobility issues in several small sessions of therapy each day, 5 days per week, increasing time in therapy as tolerance increased. An integral part of therapy would be focusing on cardio-pulmonary tolerance in mobility. The patient would learn to assess signs and symptoms of reaching his/her tolerance point and compensatory strategies to use once it is reached. Occupational therapy (OT) would address pacing and energy conservation techniques for use while performing daily living skills. Again, multiple sessions of therapy would be spread out across the day in order to allow the patient to build tolerance from a low level. The patient would need 5 days per week therapy in order to sustain the gains made and continue to build toward higher levels of independent functioning. Speech-language pathology (SLP) would also work in multiple sessions per day, 5 days per week, directing attention toward quality of breathing while eating or talking, increasing the patient's ability to provide fuel for his/her own systems as well as increasing safety in eating. Often, in all 3 disciplines (PT, OT, SLP), the therapists will have to introduce temporary basic measures for the patient and/or caregivers to follow to allow the patient to even begin to perform any of these skills him/herself. As the patient/caregivers become proficient at that level then the therapists would advance the tasks. A constant assessing and adjusting would take place as the patient made gains. A patient receiving 45 minutes per day of each discipline would exceed the $1500 dollar caps as follows: PT in 18 treatment days, OT in 16 treatment days, and SLP in 9 days. The typical medically complex patient would need at least double that time to address all his/her needs and prevent a re-occurrence which is a likelihood in this vulnerable population when needs are left unaddressed.

Patient Case Study 4

Parkinson's Disease Patient

BACKGROUND

66-year-old man who was diagnosed with Parkinson's Disease. Had been in a nursing home for 2 years because of severe dysphagia (swallowing difficulties) requiring alternate nutrition and hydration, with high-level cognitive impairments that prevented him from managing his own tube feeding and medications as well as in making safe decisions regarding his own care. His speech was quite difficult to understand by staff.

DISCUSSION OF TREATMENT

After Speech and Swallowing Therapy, he was able to consume a general diet with thin liquid and return home with functional cognitive and speech intelligibility (ability to be understood) to handle his personal business with occasional support from a neighbor. Rehabilitating the patient to this level of functional independence took 60 sessions, and 17 weeks.

Had this patient been discharged after exhausting the $1500 cap for Speech Therapy and Physical Therapy combined, he would have been unable to receive any Physical Therapy, and it is anticipated that the following level would have been his maximal ability to function at discharge:

He would have potentially been able to attempt foods for pleasure, but with great risk for aspiration. He would have continued in his historical track of recurrent aspiration pneumonia, possibly risking death from aspiration or its complications. Speech intelligibility would have remained decreased causing him to withdraw and become isolated with potential for depression. Finally, he would have remained in the nursing home unable to attend out of facility events or family events.

Patient Case Study 5

Wound Care Patient

BACKGROUND

83-year-old female admitted to a skilled nursing facility following a right hip fracture, which she suffered in a fall in her apartment. Prior to the fall, she lived alone and was able to walk with the use of a cane. Under Medicare Part A, she was seen by Physical Therapy for 10 weeks for rehab of her hip fracture. Due to restrictions on how much weight she was allowed to place on the healing fracture, she was not able to walk but improved in her abilities to move in and out of her bed and in and out of a chair.

She had a fall while on a visit with family and suffered a fracture to her right upper arm and was hospitalized. She returned to the facility after her arm fracture but had developed some areas of skin breakdown on her coccyx. She was again seen by Physical Therapy for rehab efforts. Fifteen weeks following her initial admission, her Medicare A benefits were exhausted. She was still in need of therapy services for her physical rehabilitation as well as assistance from the physical therapist for wound care and modalities to promote wound healing.

DISCUSSION OF TREATMENT

Therapy was continued under Medicare Part B for 8 weeks. At that time the patient was able to move in and out of her bed independently, move from sitting to standing independently, and was able to maneuver herself about in a wheelchair. Therapy was discontinued and nursing staff was trained to provide care to wound and assist patient with mobility. However, nursing didn't have the appropriate technology or skills to treat the wound and traditional wound care methods didn't work.

The patient was referred again to Physical Therapy by her physician approximately 4 months later. Excess scar tissue had formed along the margins of the wound, which was preventing total healing. The patient's ability to move herself from her bed and chairs also had declined. The excess callous tissue needed to be removed and wound-healing modalities applied which would facilitate total healing. The therapist was able to remove the excess callous in two weeks, and the patient continued to receive modalities for an additional 9 weeks. At the end of this period, the wound was completely healed. In addition, the patient was able to move in and out of bed independently, move on and off of the toilet independently, and was able to walk 50 feet with a walker. As a result, her quality of life was greatly enhanced and she needed nursing staff far less frequently to accomplish her daily tasks.

Cost of treatment during 1st admission: Patient received therapeutic exercises, transfer training, gait training, debridement, and electrical stimulation. Total cost $2108.25

Cost of treatment during 2nd admission: Patient received therapeutic exercises, transfer training, gait training and electrical stimulation to the wound. Total cost $2,359.70

With the $1500 therapy caps in place, this beneficiary would have been denied (or forced to pay entirely out of pocket) for services to complete her first admission and the entire second admission.

Patient Case Study 6

Alzheimer's Patient

BACKGROUND

76 year old with a diagnosis of Alzheimer's disease. Patient has resided at the Nursing Facility for the past 11 months. Upon admission, patient was able to walk to and from the dining area using a cane. She was very social and participated in activities regularly. She was able to dress herself but required reminders from staff for her to change her clothes from day to day. Approximately 6 months after admission, nurses reported that patient was losing weight and spending an increased amount of time in bed. Patient was also refusing to dress herself in the morning. In addition, the nurses reported that she had more difficulty walking to the toilet and that she has had several episodes of incontinence.

DISCUSSION OF TREATMENT

The Physical Therapist implemented a program to improve her strength, range of motion and balance. After the three-week program her ambulation skills improved significantly and patient was able to walk the dining room again using a cane.

The Occupational Therapist developed a self-care program using compensatory strategies. After 2 weeks of therapy, patient was able to do her morning self-care after set up by nursing. She was able to locate her toilet using environmental cues. Nursing reported no incidents of incontinence. The Speech-Language Pathologist implemented a program to increase patient's ability to eat safely. After three weeks of therapy she was eating more and she began to gain weight again.

Approximately 3 month after her therapy, the patient fell when walking, sustaining a minor injury. After the fall, the patient did not want to attempt walking any more. Despite staff attempts, she began spending most of her time in bed. Patient also showed a significant decline in her communication skills. Patient needs to be referred to SLP and PT for additional therapy, however she has exhausted the $1500 therapy caps for treatment.

No one can say that an Alzheimer's patient's deficits will occur in "$1500 increments" throughout a calendar year. This patient displays some of the typical problems usually associated with Alzheimer's disease and other forms of dementia. Many have problems with self-care, mobility, communication, swallowing, etc. The problems are typical however each patient is unique with varying abilities and impairment levels. Because of the progressive nature of the disease the patient may need to be seen several times during the continuum of the disease process. A recent Program Memorandum (Transmittal AB-01-135 dated September 25,2001) addresses services for Patients with dementia. This memorandum indicated that throughout the course of the disease patients with dementia might benefit from physical, occupational, speech language and other therapies.

In addition, residents who have dementia at certain cognitive levels require three weeks to learn a new habit. The $1500 caps would be depleted before new strategies could be taught to these cognitively impaired residents (followed by caregiver education to assure appropriate follow-through).

Senate Special Committee on Aging
Hearing On "Elder Justice"

Hearing Highlights

Background

Case Summary

Therapy Evaluation and Benefits

Probable Treatment Plan

Negative Impact of $1500 Therapy Caps

Senate Special Committee on Aging Hearing on "Elder Justice"

Testimony Highlights

BACKGROUND

On May 20, 2002, the Special Committee on Aging held a hearing to discuss "Elder Justice" issues. Committee Chairman, Senator John Breaux (D-LA) announced a measure to establish dual Offices of Elder Justice at the U.S. Departments of Justice (DOJ) and Health and Human Services (HHS) to detect and prevent elder abuse, neglect and exploitation of seniors living independently as well as those residing in residential care facilities.

TESTIMONY

The testimony that brought the most attention on neglect and abuse during the hearing was from Detective Graham. In January of this year, he was involved in a case of an 81-year old woman, Marie Bobo, who lived in a single family home in Tacoma. The victim's daughter had made a 911 call to the Fire Department asking for assistance with her mother who had fallen in the house. The daughter told the dispatcher that she was unable to pick her mother up.

When the Fire/Rescue arrived, they had to remove the outer door from the hinges and climb over stacks of household trash that in places went from floor to ceiling. They found the victim naked from the waist down stuck to the trash by her own feces. Pieces of her skin were pulled from her body as they lifted her for transport to an area hospital. The home was filled with human feces and rodents.

Police were summoned and responded to the hospital to interview the victim. The victim had unidentified insect life coming out of wounds on her body. She weighed 88 pounds and was malnourished and dehydrated. Ms. Bobo's legs and hips were stuck in a fetal position. She got that way from having been left, unmoved, for several months. There appeared to be no hope that her legs will ever function again.

After five months of therapy and evaluation, she could be placed in a reclining chair. The medical plan called for treatment of the tendons in her legs. This would release the limbs to the point that she could be able to sit a wheelchair.

Ms. Bobo's daughter was arrested for Criminal Mistreatment of a Dependent Person and Abandonment of a Dependent Person.

CASE SUMMARY

- Multiple wounds - infected, infested
- Malnourished
- Dehydrated
- Bilateral hip/knee contractures
- Mobility - unable

THERAPY EVALUATION AND BENEFITS

Using Marie Bobo's Facts as a Case Summary:

Initial Treatment:

Treatment: 5 months of therapy and evaluation

Result: Patient able to be placed in a recliner.

Benefits of this outcome:

- More effective position for eating/swallowing
- Ability to get out of her room – greater variety of stimulation
- Increased functional interaction in her environment
- Increased orientation
- Ability to make eye contact, enhancing socialization
- Increased functional activity for self sufficiency

Follow-Up Treatment:

Treatment Plan: requires tendon releases to get into wheelchair.

Benefits of this outcome:

- Increased self-reliance
- Decreased burden of care
- Increased participation in world around her

PROBABLE TREATMENT PLAN TO ACHIEVE THE ABOVE STATUS:

Treatment Plan	Frequency/Duration	Avg. CPT* $ per day	Total for Duration
Wound Care – selective debridement	7 days/week – 4 weeks 5 days/week – 12 weeks	(S) 97601 $40.37	$1130.36 $502422.20
ROM/ Establish Functional Maintenance Prog.	5 days/week – 4 weeks 2 days/week – 4 weeks	(T) 97110 (30 mins.) $25.82 x 2 = $51.64	$1032.80 $413.12
Mobility – bed level –rolling, repositioning	5 days/week – 6 weeks	(T) 97530 (30 mins.) $31.86 x 2 = $63.72	$1911.60
		Total cost of care	$6910.08
		Total days of care	108 days
		Total Length of Stay	152 days**

** General Florida Physician Fee Schedule rates were used to calculate, as they were the median rates of those available at the time.*

*** 16 weeks total of wound care, concurrently provided with 8 weeks of ROM/FMP establishment. First 2 weeks of mobility training will run concurrently with last 2 weeks of wound care, followed by the last 4 weeks of mobility training.*

NEGATIVE IMPACT IF $1500 THERAPY CAPS WERE IN PLACE DURING TREATMENT OF MARIE BOBO

Total CPT $$ per day:

Wound care/debridement	$40.37
ROM/FMP development	$51.64
Bed Mobility training	$63.72
Daily total	**$155.73**

Daily total	$155.73
Days of treatment	x 9.6
Total	**$1499.68**

She would receive only 9.6 days of care ($1495.00) before exceeding the caps.

Limited Therapy Scenario 1 - Wound Care Only

If she received **only Wound Care,** she would have received 17.74 days of care ($1499.75).

However, this would have only achieved minimal results in healing the wounds; they would be clean, but not filled in, and therefore susceptible to non-healing due to early wound edge attachment to wound bed surface. Her limbs would remain in the fetal position, threatening more wounds due to her:

- inability to frequently shift off of normal and abnormal weight bearing surfaces
- inability to reduce skin tension over bony prominences
- inability to reduce constant skin-to-skin contact at extremes of joint flexion
- inability to maintain proper hygiene of the contracted joints

This scenario would have left her with bilateral contractures, multiple open wounds and no hope of being able to be anywhere but in bed, and limited essentially to side-lying.

Limited Therapy Scenario 2 - Therapeutic Exercise Only

If she received **only Therapeutic Exercise**, she would have received 29.04 days of care ($1499.63).

Her probable plan of treatment above called for her to receive 28 days of Therapeutic Exercise over 8 weeks, with varying frequency accommodating for the change from skilled therapy to restorative nursing. Without wound care to improve the condition of the extremities to be exercised, it is likely that skilled therapy would have to remain in the picture longer to ensure that the condition of the wounds and the exercise program did not interfere with each other. A maintenance program would be established, however, since her inability to self-reposition would remain due to a lack of Bed Mobility Training, it would be expected that wounds and joint contractures would continue to plague her.

Limited Therapy Scenario 3 - Bed Mobility Training Only

If she received **only Bed Mobility Training**, she would have received 23.54 days of care ($1499.97).

Without having gained any joint flexibility in her lower extremities and lower trunk, she would have a difficult time improving her ability to self-reposition. The inability of the lower extremities to assist in shifting positions and weight bearing surfaces would lead to increased shearing forces on the skin likely increasing the potential for more skin breakdown due to her malnourished and dehydrated state.

Support for Therapy Caps Repeal

Letters and Media

House "Dear Colleague" Letter

Senate "Dear Colleague" Letter

Letter to President Bush from Industry Associations

Repeal Ad - "Roll Call" Newspaper, 4/29/02, page 14

Congress of the United States
Washington, DC 20515

Don't Penalize the Oldest and Sickest of Our Medicare Seniors

Dear Colleague:

Please join us as a cosponsor of the *Medicare Access to Rehabilitation Services Act of 2002* to repeal the $1,500 Medicare beneficiary therapy cap. As you may know, the Balanced Budget Act of 1997 included an arbitrary $1,500 cap on most outpatient rehabilitation services. Unfortunately, the $1,500 limits were adopted without the benefit of committee hearings or detailed analysis by the then-Health Care Financing Administration of their likely effects on beneficiaries' ability to obtain medically necessary services.

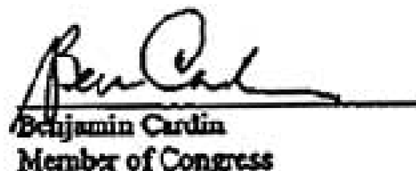
Congress has already shown its opposition to this arbitrary $1,500 cap by placing a moratorium on it in 1999. One year later, Congress extended the moratorium until January 2003. Without Congressional action, the beneficiary cap on therapy services will be effective again in just over a year. It is time to repeal the cap once and for all.

Most individuals who need rehabilitation therapy would not exceed $1,500 of care in a given year. However, it is unfair to require beneficiaries who need more care to pay 100% out-of-pocket for it. It would be those beneficiaries who suffer from stroke, Parkinson's disease, or other chronic debilitating conditions who would likely exceed the $1,500 therapy cap. Repealing the cap would cost less than $100 million in fiscal year 2003 and approximately $500 million over 5 years according to a cost estimate by PricewaterhouseCoopers. The oldest and sickest Medicare beneficiaries should not be forced to shoulder this burden.

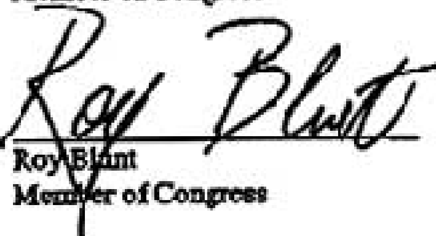
Our legislation simply ensures that the payment system for rehabilitation services reflects the needs of Medicare beneficiaries based on their condition rather than an arbitrary monetary amount. We urge you to join us in repealing the $1,500 therapy cap and establishing a system that makes sense. If you are interested in becoming a cosponsor this bill or for more information, please contact Julie Ufner in Phil English's office at 5-5406, Priscilla Ross in Benjamin Cardin's at office 5-4016, Annissa McDonald in Roy Blunt's office at 5-6536, or Kathy Kulkarni in Frank Pallone's office at 5- 4671.

Sincerely,

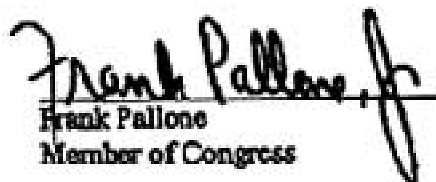
Phil English
Member of Congress



Benjamin Cardin
Member of Congress



Roy Blunt
Member of Congress



Frank Pallone
Member of Congress

PRINTED ON RECYCLED PAPER

United States Senate

WASHINGTON, DC 20510

February 26, 2002

<u>Don't Penalize the Oldest and Sickest of Our Medicare Seniors</u>

Cosponsor S. 1394

Dear Colleague:

Please join us as a cosponsor of the ***Medicare Access to Rehabilitation Services Act of 2001*** **(S. 1394)** to repeal the $1,500 Medicare beneficiary therapy cap.

As you may know, the Balanced Budget Act of 1997 included an arbitrary $1,500 cap on most outpatient rehabilitation services. Unfortunately, the $1,500 limits were adopted without the benefit of committee hearings or detailed analysis by the then-Health Care Financing Administration of their likely effects on beneficiaries' ability to obtain medically necessary services.

Congress has already shown its opposition to this arbitrary $1,500 cap by placing a moratorium on it in 1999. One year later, Congress extended the moratorium until January 2003. Without Congressional action, the beneficiary cap on therapy services will be effective again in just over a year. It is time to repeal the cap once and for all.

Most individuals who need rehabilitation therapy would not exceed $1,500 of care in a given year. However, it is unfair to require beneficiaries who need more care to pay 100% out-of-pocket for it. It would be those beneficiaries who suffer from stroke, Parkinson's disease, or other chronic debilitating conditions who would likely exceed the $1,500 therapy cap. Repealing the cap would cost less than $100 million in fiscal year 2003 and approximately $500 million over 5 years according to a cost estimate by PricewaterhouseCoopers. The oldest and sickest Medicare beneficiaries should not be forced to shoulder this burden.

Our legislation simply ensures that the payment system for rehabilitation services reflects the needs of Medicare beneficiaries based on their condition rather than an arbitrary monetary amount. We urge you to join us in repealing the $1,500 therapy cap and establishing a system that makes sense. If you are interested in becoming a cosponsor of S. 1394, please contact Aaron Cohen in Senator Ensign's office at 224-6244 or Elizabeth MacDonald in Senator Lincoln's office at 224-4843.

Sincerely,

John Ensign

Blanche Lincoln

January 25, 2002

President George W. Bush
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Bush:

As you prepare to deliver your State of the Union address, we ask that you fix a law that requires the sickest of Medicare beneficiaries to pay more for therapy services.

Several years ago, Congress enacted a law that imposed a $1,500 limit on annual Medicare Part B therapy services. Unless there is some type of intervention, on December 31, 2002, a congressionally-imposed moratorium on this limit will expire, thereby allowing the resumption of beneficiary limitations to outpatient rehabilitation therapy care. This cap or financial limitation was imposed on Medicare beneficiaries for calendar year 1999, and government sponsored reports are just now showing the negative impact the cap had on the provision of care during that year.

The Medicare outpatient rehabilitation therapy cap is a beneficiary cap as a result of the *Balanced Budget Act of 1997* (BBA). The $1,500 therapy cap would apply to Medicare beneficiaries in all outpatient health care settings, with the exception of hospital outpatient departments. While most Medicare beneficiaries would never exceed the annual cap, it would force approximately 13% of the senior citizens who need such care the most to decide between forgoing necessary care or paying 100% of the cost out-of-pocket. Beneficiaries who suffer from a stroke, hip fracture or have Parkinson's disease or osteoporosis are more likely to be the type of patient needing such care.

Congress delayed this cap. In December of 1999, Congress placed the $1,500 cap under a two-year moratorium. In addition, nearly 60 Senators and over 120 Representatives recognized the problems associated with the beneficiary cap by supporting legislation in 1999 to create numerous therapy cap exceptions. Then in 2000, Congress further extended the beneficiary cap moratorium by one year. Unfortunately, the cap will be back on January 1, 2003 if no action is taken.

Mr. President, while we realize that the horrible events of September 11th have resulted in a necessary re-prioritization of domestic policies, we ask that you consider this crucial health care issue and support the repeal of this arbitrary cap, which has the potential to significantly impact Medicare beneficiaries nationwide.

Sincerely,

Alzheimer's Association
American Association of Homes and Services for the Aging
American College of Health Care Administrators
American Federation of State, County and Municipal Employees
American Health Care Association
American Medical Directors Association
American Medical Rehabilitation Providers Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
Council on Social Work Education
Easter Seals
National Association Directors of Nursing Administration Long Term Care
National Association for Rehabilitation Agencies
National Association for the Support of Long Term Care
National Association of Social Workers
National Citizens Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Spinal Cord Injury Association
Paralyzed Veterans of America
Private Practice Section, APTA