

Sample Letter to Your U.S. Representative

Note: If you are not sure of the name of your U.S. Representative, call the ASHA Action Center at 800-498-2071, or visit ASHA's Gateway to Action at www.asha.org.

<On your business or home stationery>

<date>

The Honorable *<Insert full name>*
United States House of Representatives
Washington, DC 20515

Dear Representative *<insert last name>*:

Medicare beneficiaries need your help to change an ill-advised policy put in place by the Balanced Budget Act (BBA) of 1997. Beginning this year, a new payment cap of \$1500 was placed on Medicare outpatient rehabilitation services. I ask you to co-sponsor and support H.R. 1837, The Medicare Rehabilitation Benefit Improvement Act of 1999, which remedies this detrimental policy by providing an exceptions process for patients who require medically-needed services and exceed this punitive cap. This arbitrary limit is already creating service disruptions, forcing patients and their families to indirectly ration or forego medically needed care in our district.

To make matters worse, the Health Care Financing Administration (HCFA) interpreted the \$1500 cap as a combined payment limit for both speech-language pathology and physical therapy services. Speech-language pathology is a separate discipline that addresses different clinical needs of Medicare beneficiaries from physical therapy and is recognized as a distinct Medicare benefit subject to different payment and coverage provisions. Patients who have had a stroke or head trauma are put in a no-win situation, where they must choose one service over another, or have severely reduced services in both.

The \$1500 cap is arbitrary and unnecessary. Prior to this ill-advised policy, there has never been a limit on Medicare speech-language pathology (SLP) services. To assure appropriate utilization, national guidelines for medical necessity were developed by HCFA and speech-language pathologists. Moreover, this year Medicare instituted a Prospective Payment System (PPS) that is relative-value fee schedule for SLP services modeled on the physician payment methodology. The cap only serves to disrupt needed services and is costing my patients in time, anguish, and in the discontinuity of care. Combined, these factors will likely cost Medicare more money.

Speech-language pathology services improve communication skills and swallowing abilities that increase patients' independence, reducing the need for assistance by nurses, family members or other caregivers, (e.g., ceasing the use of a feeding tube). Without these abilities that we take for granted, their lives take on a greater burden that extends to their families, caregivers and ultimately the Medicare system.

Thank you for your thoughtful consideration of this important matter.

Sincerely,

<Your name>

ISSUE SUMMARY: \$1500 Cap on Medicare Outpatient Rehabilitation Services

Beginning January 1, 1999, Section 4541 (c) of the Balanced Budget Act of 1997 (P.L. 105-33) incorporated a new annual payment cap on speech-language pathology (SLP) services furnished to Part B Medicare outpatients in skilled nursing facilities, rehabilitation agencies, public health agencies, clinics, or comprehensive outpatient rehabilitation facilities at \$1500 per patient.

ACTION REQUESTED

Ask your Representative to please consider co-sponsoring H.R. 1837, the “Medicare Rehabilitation Benefit Improvement Act of 1999”. Its companion Senate bill, S. 472 now has more than 50 co-sponsors. This legislation would permit access to medically needed outpatient rehabilitation services by establishing an exception process for patients who exceed this arbitrary cap.

BACKGROUND

The following are ASHA’s specific concerns related to the \$1,500 cap on outpatient rehabilitation services for Medicare patients:

- Older Americans, especially in long-term care facilities, who have exhausted the \$1500 limit, will have no choice but to disrupt their care and seek it in less accessible hospital outpatient departments, rather than with providers such as skilled nursing facilities, rehabilitation agencies, independent practitioners, and comprehensive outpatient rehabilitation facilities (CORFs).
- Placing speech-language pathology and physical therapy under a shared \$1500 cap puts patients at an even greater risk of receiving inadequate services and indirectly forces patients and their families to ration medically-needed care, effectively capping speech-language pathology services far below this amount.
- Speech-language pathology services represent only 9 percent of Medicare’s outpatient rehabilitation spending and have had a negligible history of fraud and abuse in comparison to other rehabilitation services.
- Speech-language pathology is a separate profession that addresses different clinical needs of Medicare beneficiaries from physical therapy. Medicare statutory and regulatory law has historically recognized these two professions as distinct Medicare benefits subject to different payment and coverage provisions.

TALKING POINTS: Medicare Rehabilitation Benefit Improvement Act of 1999

The Cap May Cause Patients to Refuse Medically Necessary Treatment.

- Faced with an annual cap of \$1500, a stroke victim may choose to delay or refuse medically necessary services for fear of exhausting their cap.
- This will ultimately drive treatment costs up significantly, as conditions worsen until acute care is needed. For example, aphasia or dysphasia left untreated can cause aspiration pneumonia which will require hospitalization, ultimately costing Medicare more than \$20,000 to treat.

While The Cap Is Intended To Result In Overall Medicare Savings, It May Actually Result In Increased Treatment Costs.

- Patients who have exhausted their \$1500 limit in an outpatient rehabilitation facility will likely disrupt their care and seek it in more expensive hospital outpatient settings, ultimately costing Medicare more for the same treatment.

Including Physical Therapy and Speech-Language Services Under the Same Cap is Inconsistent With Past Medicare Policy.

- Medicare has historically recognized speech-language pathology and physical therapy as separate and distinct disciplines addressing different treatment needs.
- They have historically been subjected to different payment and coverage provisions under Medicare statutory and regulatory law.
- Including them under a single cap is unfair and unsound medical policy.

The Best Remedy For The Situation Is To Allow Exemptions In Cases Where It Is Medically Necessary.

- Allowing exemptions in cases where more treatment is needed is the best way to ensure that patients get the care they need and that Medicare costs are contained.
- Allowing exemptions ensures that patients can receive the full course of treatment necessary to address their particular medical needs in cost-efficient settings, such as outpatient rehabilitation facilities, rather than in hospitals.

Support Passage of the Medicare Rehabilitation Benefit Improvement Act of 1999

- H.R. 1837 and its Senate companion bill, S. 472, would allow exemption from the cap for patients whose condition requires more care, or for patients who have a subsequent incident resulting in a need for additional care after exhausting their limit.
- Congress will take these bills up again when they come back from recess on September 7th. We urge Congress to pass this important legislation to rectify this arbitrary and unnecessary policy.

Co-sponsors of H.R. 1837 (as of August 17, 1999)

Alabama

Bob Riley (R-3rd)
Earl Hilliard (D-7th)

Arkansas

Marion Berry (D-1st)
Jay Dickey (R-4th)

California

Doug Ose (R-3rd)
Anna Eshoo (D-14th)
Lois Capps (D-22nd)
Elton Gallegly (R-23rd)
Julian Dixon (D-32nd)
Juanita Millender-McDonald (D-37th)
Gary Miller (R-41st)

Colorado

Joel Hefley (R-5th)

Connecticut

James Maloney (D-5th)
Nancy Johnson (R-6th)

Florida

Charles Canady (R-12th)
Mark Foley (R-16th)
Peter Deutsch (D-20th)
Lincoln Diaz-Balart (R-21st)
Alcee Hastings (D-23rd)

Georgia

Nathan Deal (R-9th)

Illinois

Jerry Costello (D-12th)
David Phelps (D-19th)

Indiana

David McIntosh (R-2nd)

Kentucky

Edward Whitfield (R-1st)
Ron Lewis (R-2nd)
Ken Lucas (D-4th)

Louisiana

Jim McCrery (R-4th)
Richard Baker (R-6th)

Massachusetts

Richard Neal (D-2nd)
James McGovern (D-3rd)
Barney Frank (D-4th)
Marty Meehan (D-5th)

Maryland

Elijah Cummings (D-7th)

Maine

John Baldacci (D-2nd)

Michigan

Dave Camp (R-4th)
James Barcia (D-5th)
Fred Upton (R-6th)
Dale Kildee (D-9th)

Missouri

James Talent (R-2nd)
Roy Blunt (R-7th)
Kenny Hulshof (R-9th)

Mississippi

Ronnie Shows (D-4th)

Montana

Rick Hill (R-AL)

North Carolina

Bob Etheridge (D-2nd)
David Price (D-4th)
Richard Burr (R-5th)
Mike McIntyre (D-7th)

North Dakota

Earl Pomeroy (D-AL)

Nebraska

Doug Bereuter (R-1st)

New Hampshire

John Sununu (R-1st)

New Jersey

Robert Andrews (D-1st)
Frank LoBiondo (R-2nd)
Frank Pallone (D-6th)
Rush Holt (D-12th)

Nevada

Shelley Berkley (D-1st)
James Gibbons (R-2nd)

New York

Jerrold Nadler (D-8th)
James Walsh (R-25th)
Maurice Hinchey (D-26th)

Ohio

Michael Oxley (R-4th)
Ted Strickland (D-6th)
Dennis Kucinich (D-10th)
Sherrod Brown (D-13th)
James Traficant (D-17th)
Steven LaTourette (R-19th)

Oregon

Darlene Hooley (D-5th)

Pennsylvania

Mike Doyle (D-18th)
Frank Mascara (D-20th)
Philip English (R-21st)

Rhode Island

Robert Weygand (D-2nd)

South Carolina

John Spratt (D-5th)

Tennessee

William Jenkins (R-1st)
John Tanner (D-8th)
Harold Ford (D-9th)

Texas

Max Sandlin (D-1st)
Ralph Hall (D-4th)
Charles Stenholm (D-17th)
Larry Combest (R-19th)
Martin Frost (D-24th)
Gene Green (D-29th)

Utah

James Hansen (R-1st)
Merrill Cook (R-2nd)

Virginia

Virgil Goode (D-5th)
Bob Goodlatte (R-6th)
James Moran (D-8th)
Rick Boucher (D-9th)

Washington

Brian Baird (D-3rd)

Wisconsin

Ron Kind (D-3rd)

West Virginia

Nick Rahall (D-3rd)

Wyoming

Barbara Cubin (R-AL)