



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

Statement

of the

American Speech-Language-Hearing Association

to the

Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives

Hearing on Medicare Balanced Budget Refinements

**PROBLEMS WITH THE ARBITRARY THERAPY CAPS**

Presented by Nancy B. Swigert

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Thank you, Chairman Thomas and Members of the Committee, for allowing me to appear before you today. My name is Nancy Swigert, and I am the owner of a private practice in Kentucky. I personally provide speech-language pathology clinical services, and I am the immediate past president of the American Speech-Language-Hearing Association (ASHA), which represents nearly 100,000 speech-language pathologists, audiologists, and speech, language and hearing scientists. We also work closely with the other national rehabilitation professional organizations – the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) – on the issues related to today's hearing; in total representing some 300,000 rehabilitation therapy professionals.

On behalf of these professionals and our patients, we appreciate the opportunity to present our views to this Subcommittee concerning problems in the implementation and refinements to the Medicare provisions in the Balanced Budget Act (BBA) of 1997 impacting services to outpatient rehabilitation beneficiaries. As Congress prepares to consider BBA refinements, ASHA urges inclusion of improvements that relate to outpatient rehabilitation services in any “BBA fix” legislation approved by the Subcommittee, specifically the \$1500 beneficiary cap on a combined speech language pathology/physical therapy benefit. This provision, which also includes a separate \$1500 cap on outpatient occupational therapy, was enacted to control "inappropriate" utilization of outpatient rehabilitation services by requiring beneficiaries to pay for services that exceed the cap.

However, what this provision has done is disrupt treatment for many and denied seniors, especially those who are the sickest, the necessary services they need so that they can return to functional levels in the most fundamentally human skills of swallowing, speaking and walking. As implemented, the burden of the utilization policy is being born chiefly by high-acuity patients, such as individuals recovering from stroke, hip injuries and medically-complex cases that result in multiple medical incidents within a single year.

In testimony previously given before other congressional hearings on the impact of this policy from the BBA, we believe representatives from federal agencies have trivialized and underestimated the number of Medicare beneficiaries who will exceed the caps, and will consequently face either disrupted and costlier care or denied care. Moreover, it is our strong contention that government assessments about the impact of these caps is significantly underestimated due to the self-rationing by patients and their families, as well as widespread confusion about how this policy has been implemented. Mr. Chairman and Members of the

Committee, I ask that you not to let them play down the severe impact of the caps are having on the hundreds of thousands of our sickest Medicare patients.

To make matters worse, in implementing this provision, the Health Care Financing Administration (HCFA) ruled that the speech-language pathology and physical therapy were to share \$1500 for those Medicare outpatients who required both, citing the BBA provision that included speech-language pathology services (SLP) with physical therapy (PT) services. This action set an ugly precedent, disregarding the whole of Medicare and Medicaid regulations developed since 1972, when “speech pathology services” were added as a benefit, as well as all clinical and practice standards that clearly recognize speech-language pathology and physical therapy as separate and very distinct services. Essentially, the 1972 amendment adding speech-language pathology services was re-interpreted to mean that Medicare outpatient speech-language pathology is a part of Medicare outpatient physical therapy, even though there is a separate definition in the statute (Section 1861(I)) of the Social Security Act) for speech-language pathology services. ASHA protested the interpretation and provided HCFA with a legal analysis that, we believe, gives the agency adequate flexibility in correcting this problem. While sympathetic with our case, HCFA has cited that it does not have the authority to make such a change. Mr. Chairman, we have appreciated your personal efforts to administratively correct this situation. But in the absence of action by the agency, we urge the Committee to legislatively make the technical corrections necessary to resolve this unintended consequence of the BBA.

While I could provide the Committee with case after case of real life examples – even within my own family – of how Medicare beneficiaries’ lives have been negatively changed, I would like to share with you a summary of a recently completed randomized survey of speech-language pathologists who reside in Texas, North Carolina, Connecticut, and

California. The survey investigated the impact of recent changes in Medicare reimbursement policies on the access patients have to the care provided by speech-language pathologists, and the nature of the possible consequences to the well being of these patients if the care is not available.

In brief, clinicians estimated that 23% of patients who were covered under Part A and 70% of the patients covered under Part B were expected to be denied speech-language pathology care due to restrictions directly resulting from BBA policy changes. According to the clinicians, the most frequently cited consequence of denied care was the potential for an increased risk of aspiration pneumonia and dehydration, while also noting that these patients would likely experience an inability to resume normal daily activities and would continue to rely on a caregiver. Mr. Chairman, I believe that this study reconfirms our most grave concerns about the negative impact and unintended consequences of some BBA policy decisions.

While it would be our strong preference that Congress simply repeal these arbitrary beneficiary caps on therapy services, ASHA believes Congress needs to take immediate actions to make reasonable refinements in these policies so that appropriate and necessary care to our seniors is not sacrificed. I would ask you, Mr. Chairman, and Members of the Committee, to consider two specific options that Congress can do to this end:

First, as sponsored by a number of Members of the Committee, enact the Burr/Grassley legislation (H.R 1837 and S. 742) that retains the cap except in those instances where the patient needs the additional services. Specifically, if a patient has a dual diagnosis; has two episodes of illness in one year; or is at risk of hospitalization. We worked on this legislation because we understood Congressional wishes to control utilization of this benefit.

However, this benefit is intended to improve patient care and exceptions should be made for those patients who need the services and avoid costly inpatient hospitalizations.

Second, separate the shared cap between speech-language pathology and physical therapy services, and recognize in legislation the independent services being provided by speech-language pathologists. Because of misdirected interpretation of the BBA therapy cap provision, there needs to be a distinction made – as a matter of law and public policy – between the offering of speech-language pathology and physical therapy services. As a provider, I treat people who have had strokes relearn to swallow. More deaths result from asphyxiation following a stroke than any other complication. As a provider, I treat people who can not communicate. Relearning these skills is time consuming, especially for a patient who has had a massive stroke or who have Parkinson’s Disease. These are services that are very different from physical therapy. I urge this Committee to distinguish these types of care and not force a patient to chose whether he or she will be able to swallow or walk again because of the unintended consequence of this combined cap on SLP and PT services.

Under current law, a speech-language pathologist can provide services as an independent practitioner; however, they must send their bills through either a physical therapist or a physician. This benefit is in current law. We are merely asking that you establish us with the same level of billing authority as physical and occupational therapists. By function of law, this would then extend the current two caps to three caps. Combining this with the Burr/Grassley legislation allows for two important improvements:

- 1) when patients are seriously ill, their care can continue without the beneficiary having to pay out-of-pocket for services;

- 2) for other patients seeking therapy services that do not fall into this category, they would have \$1500 cap in speech-language pathology services; \$1500 in physical therapy services; and \$1500 in occupational therapy services.

Mr. Chairman and Members of the Committee, on behalf of ASHA and the other rehabilitation professional groups, we appreciate your efforts to rectify the problems presented by the current therapy caps, as well as the opportunity to discuss our views on this critically important matter. We urge you to take action to remedy the unintended consequences caused by the implementation of these arbitrary caps, and we look forward to working with Congress and HCFA to fix these problems.