



## **Statement for the Record**

**Submitted by APTA Private Practice**

**to**

**U.S. House Ways & Means Health Subcommittee**

**Hearing Titled; “The Collapse of Private Practice:  
Examining the Challenges Facing Independent Medicine”**

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**APTA Private Practice**

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On behalf of the almost 4,000 members of APTA Private Practice, a section of the more than 100,000-member American Physical Therapy Association (APTA), we appreciate the opportunity to submit the following Statement for the Record to the U.S. House Ways & Means Health Subcommittee as part of the hearing entitled; “The Collapse of Private Payment: Examining the Challenges Facing Independent Medicine.”

As experts in rehabilitation, prehabilitation, and habilitation, physical therapists (PTs) play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span. Physical therapists help individuals improve their overall health and prevent the need for avoidable health care services. Like others who took a chance to work in the private practice sector of health care, our membership owns, operates, and works in private practice settings. APTA private practice members put their patients first, while also taking on the role of business owners, with expertise in management, billing, and marketing, amongst a long list of other non-clinical tasks.

Physical therapists face unique challenges under the Medicare Physician Fee Schedule (MPFS). Physical therapists and physical therapist assistants (PTAs) play a critical role in the delivery of services to beneficiaries who have chronic care conditions; however therapists and other non-physician providers who are paid under the MPFS are often overlooked when it comes to enacting meaningful reforms to payment and administrative burden challenges.

We are dedicated to working with you to make changes in order to keep our members in business and continuing critical access to physical therapy services for Medicare beneficiaries. As we outline below, there are common sense policy changes we can achieve to address the barriers PTs are continuously facing as it relates to inadequate payment, administrative burden, workforce challenges, and anti-competitive business practices.

### **Inadequate Medicare Payment**

Over the last three years, therapy providers have received some of the largest cuts of any health care provider as a result of budget neutrality policies. At the same time, therapy providers are subject to legacy reductions to payment for services that date back to the days of the sustainable growth rate (SGR) formula, excessive administrative costs, and lack of opportunities to participate in innovative and value-based programs.

The financial pressures of declining Medicare payments and escalating administrative burdens are impacting practices and their patients. In a survey of our membership this year, private practice PTs had to make difficult decisions in order to avoid complete financial ruin by doing the following: closing clinics, reducing clinic hours, and/or waitlisting patients. As physical therapy is not an acute service, patients with limited access may see furthering decline in their condition and may not easily be able to find a convenient alternative for ongoing care. We believe there is a better way forward in order to not hinder patient care and bankrupt private practices.

### *Reform the Medicare Physician Fee Schedule*

Providers under the MPFS do not receive the annual inflationary update which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. Providing an annual inflationary payment update to the MPFS' conversion factor (CF) based on the Medicare Economic Index (MEI) will provide much-needed stability to the Medicare payment system. The MEI is a measure of inflation faced by health care providers with respect to their practice costs and general wage levels.

Health care providers, including physical therapists, continue to face increasing challenges as they seek to provide Medicare beneficiaries with access to timely and quality care. Congress has taken action to mitigate some of the recent Medicare Fee Schedule cuts on a temporary basis, nevertheless, reimbursement continues to decline.

The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and the lack of opportunity for positive payment adjustments through the Quality Payment Program (QPP), clearly demonstrates that the fee schedule is broken. Increasingly thin operating margins disproportionately affect small, independent, and rural practices, as well as those treating low-income or other historically under-resourced or marginalized patient communities.

An inflationary update will provide budgetary stability to clinicians - many of whom are small business owners— as they contend with a wide range of shifting economic factors such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. It will also help providers invest in their practices and implement new strategies to provide high-value care. We support and encourage the Subcommittee to consider H.R. 2474, Strengthening Medicare for Patients and Providers Act led by Representatives Raul Ruiz, MD (CA-25), Larry Bucshon, MD (IN-08), Ami Bera, MD (CA-06), and Mariannette Miller-Meeks, MD (IA-01).

### *Eliminate an Outdated and Flawed Therapy-Specific Medicare Payment Policy*

The Multiple Procedure Payment Reduction (MPPR) policy was first implemented in 2011 and applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one “always therapy” service (identified by the Current Procedural Terminology (CPT) code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code. Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy providers, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced.

In the 2011 MPFS, the Centers for Medicare & Medicaid Services (CMS) first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction

amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from January 1, 2011 to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

The American Physical Therapy Association, APTA Private Practice, American Occupational Therapy Association, and the American Speech-Language-Hearing Association have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association RVS Update Committee (RUC), which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes.

The application of MPPR to the “always therapy” codes results in an excessive and duplicative reduction of these codes and is having a significant impact on the financial viability of therapy practices, and ultimately impacting access to vital therapy services. The percentage of payment reduction was arbitrarily decided and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that PT, occupational therapy (OT), and Speech-Language Pathology (SLP) interventions are separate and distinct from each other.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline delivering services on that date would have all provided service units reduced. This occurs even though the equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided.

This policy penalizes providers when scheduling multiple therapies on the same date which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic to receive separate therapy discipline services. We encourage the Subcommittee to fix this outdated law to provide fair relief to therapy providers.

#### *Allow Medicare Patients Choice in Their Therapy*

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers if they provide services to Medicare-eligible beneficiaries. Opting out of Medicare to allow for direct contracting with patients, a practice afforded to other providers, would ultimately improve access to care, rather than have therapy providers refuse Medicare patients due to reimbursement challenges noted above. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program. Other providers, including physicians, physician assistants, dentists, podiatrists,

optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers already have this right. Therapists should have the same rights as other health care providers in this regard.

Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare can also negatively impact patients' clinical outcomes. It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs. Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies.

Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access. According to an independent report published by Dobson & Davanzo in October 2023, allowing physical therapists, occupational therapists, and speech-language pathologists to opt-out is estimated to save the federal government \$139.6 million over ten years.

### **Administrative Burden**

Given the current pressures on therapy providers, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapist providers.

#### *Reform Medicare Advantage Prior Authorization*

Prior authorization frequently results in administrative burdens for providers which diverts precious time away from patient care and delays approval for necessary physical therapy services. It is not uncommon for therapists to follow all required guidelines from a Medicare Advantage (MA) plan and still receive rejections. Furthermore, it is not clinically appropriate to ration care solely based upon the volume of services. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and utilization management hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. We look forward to working with the Subcommittee on new legislation this Congress to address these concerns.

#### *Create a Sensible Plan of Care*

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment. The time and resources spent by both

therapists and physicians in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

We support and encourage the Subcommittee to consider H.R. 7279, the Remove Duplicative Unnecessary Clerical Exchanges (REDUCE) Act, bipartisan legislation led by Representatives Lloyd Smucker (PA-11) and Don Davis (NC-1). This policy would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist.

For a physician who ordered therapy services, they would have 10 business days after receiving the plan of care to modify it. When a patient began therapy services without an order, the receiving physician would have 30 calendar days to modify the plan of care.

#### *Align Supervision Requirements of PTAs Across Medicare*

Medicare allows for general supervision of physical therapy assistants by PTs, and occupational therapy assistants (OTAs) by OTs, and in all settings, except for outpatient private practice under Medicare Part B, which requires direct supervision. Medicare doesn't even require PTAs practicing in intensive care units (ICUs) to have direct supervision – general is sufficient.

While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision of PTAs and OTAs, making this outdated Medicare regulation impacting only private practices more burdensome than almost all state requirements. Standardizing a general supervision requirement for private practices will help ensure continued patient access to needed therapy services and give small PT private practices more workforce flexibility to meet the needs of beneficiaries.

We support and encourage the Subcommittee to consider H.R. 4878, the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation (EMPOWER) Act led by Representatives Debbie Lesko (AZ-8) and Annie Kuster (NH-2). This policy addresses the problem by enacting language to change the Medicare supervision requirement for PTAs and OTAs in private practice from direct to general supervision in states with licensure laws that allow for it.

This legislation would also direct the Government Accountability Office (GAO) to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by PTAs and OTAs, which went into effect in 2022, has impacted access to physical therapy and occupational therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive PT or OT services from an assistant. The GAO report will make it clear whether this payment differential is disproportionately impacting these regions.

According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision is estimated to save the federal government \$271 million over 10 years.

### *Allow Uninterrupted Access to Physical Therapy*

The ability to bring in a replacement provider during a provider's temporary absences for illness, pregnancy, vacation, or continuing medical education is known as locum tenens.

The 21st Century Cures Act of 2016 contained a provision that added physical therapists to the health care professionals who may use locum tenens under Medicare. This allows a physical therapist to bring in another licensed physical therapist to treat Medicare patients and bill Medicare through the practice provider number during temporary absences. The law, however, applies only to physical therapists in non-Metropolitan Statistical Areas, Medically Underserved Areas (MUAs), and Health Professions Shortage Areas (HPSAs) as defined by the U.S. Department of Health and Human Services (HHS). This limitation prohibits many physical therapists in private practice from taking needed absences without interrupting patient care. Locum tenens arrangements are beneficial to both patients and providers, as care is continued by another licensed, qualified provider during a temporary absence.

We support and encourage the Subcommittee to consider H.R. 1617, the Prevent Interruptions in Physical Therapy Act of 2023 led by Representatives Gus Bilirakis (FL-12) and Paul Tonko (NY-20). This legislation would enable all physical therapists to utilize locum tenens arrangements under Medicare regardless of the geographic area or population served.

### **Workforce Challenges**

The constant downward pressure on reimbursement and various administrative burdens has had a significant impact on physical therapist and physical therapist assistant workforce issues. In October 2023, APTA Private Practice and APTA released a joint report, "APTA Benchmark Report: Hiring Challenges Continue in Outpatient Physical Therapy Services."<sup>1</sup> The report calls for expanded need for PTs in the outpatient setting. Over 22,000 PT providers left the profession during the COVID-19 pandemic leaving a void for clinics seeking to hire qualified physical therapists, especially in rural settings.

The vast majority of practices reported openings of at least 5%, with a 10.1% total vacancy rate across all employee categories (physical therapists, physical therapist assistants, and support personnel). This was down from the 2022 report of a 16% total vacancy rate.

While the overall vacancy rate was lower in 2023 compared with 2022, hiring challenges are increasing for many practices. Almost 40% of practices with openings are facing a higher vacancy rate now than they did last year. The distribution of vacancy rates varies by position type, clinic size, and location. Company growth was the most frequently cited reason for current position openings, pointing to a greater need overall for physical therapist services.

As private practice PTs, we compete with a multitude of settings for talent and more often than not, we are unable to compete financially with larger health care systems who can provide higher salaries. This problem is magnified when attempting to staff clinics in rural areas.

### **Anti-Competitive Business Arrangements**

Rapid consolidation and vertical integration in health care has led to anti-competitive business arrangements that limit patient choice, increase cost, and create an unlevel playing field for private practitioners. A study reported in JAMA Health Forum in September of 2023 supports our members' reality by concluding that primary care physicians in large health systems steer patients to their health system resulting in increased costs of care.<sup>ii</sup> Often using physician incentives to minimize the "leakage" of referrals that go outside their system. We encourage and support legislation that re-levels the playing field for providers and ensures all patients have real choice in the care they need.

### **Conclusion**

The pressure on private practice health care is impacting all providers, not just physicians. When faced with year after year payment cuts, the inability to keep staff, the administrative burdens we bear from Medicare, all while trying to provide the best care we can for our patients, it's not difficult to imagine a scenario where access to care is lost or further consolidation is realized. We are determined to find a way forward to make things better for PT private practices and our patients. We look forward to working with you on the unique challenges our members face.

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<sup>i</sup> <https://www.apta.org/news/2023/10/18/vacancy-report-2023>

<sup>ii</sup> JAMA Health Forum, Anna D. Sinaiko, PhD; Vilsa E. Curto, PhD, Katherine Ianni, BA; et al., Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems, September 1, 2023. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2808890>