APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

**Comments of the
American Physical Therapy Association**

Health Subcommittee of the House Committee on Ways and Means

Tuesday, July 17, 2018

For a hearing titled

"Modernizing Stark Law to Ensure the Successful Transition from Volume to Value in the Medicare Program**"**

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Health Subcommittee of the House Ways and Means Committee as the committee evaluates how the US Department of Health and Human Services (HHS) will reform the Stark Law to allow for greater flexibility in participation in alternative payment models (APMs). The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA stands firmly committed to the goals of the Administration to move health care delivery in a direction that values quality of care over volume, and we look forward to working with Congress and HHS to identify methods by which physicians can be encouraged rather than penalized for entering into arrangements under a value-based care model. We are particularly dedicated to working with Congress and HHS to promote increased nonphysician participation in value-based care models.

APTA has diligently advocated for the development of new value-based payment models that promote access to rehabilitative services. Through our advocacy efforts, we have

encouraged HHS to consider a more thorough integration of nonphysician practitioners, such as physical therapists, in the design and implementation of future value-based payment models. Additionally, we have recommended that HHS work with APTA and other stakeholders in creating innovative models that incorporate rehabilitation and care provided by nonphysicians and explore options for certifying these models as Advanced Alternative Payment Models (Advanced APMs) under the Quality Payment Program. We also believe it is critical that HHS, and specifically the Centers for Medicare and Medicaid Services (CMS), solicit input and engage in meaningful dialogue with small physical therapy practices when creating future payment models to ensure that a key demographic of providers is adequately represented.

Physical therapists are well-positioned to be rewarded based on the value of the care they provide to their patients. However, the existing Medicare APMs fail to promote collaboration with small- and medium-sized physical therapy and other nonphysician practices, as these providers frequently are not viewed as foundational partners by larger providers, such as integrated health systems. Secretary Azar has expressed that HHS is committed to creating a "true competitive playing field" that rewards value. To achieve Secretary Azar's objective, HHS, must take into greater consideration the differences between physical therapists and other providers, and account for those differences as it pursues the development of new APMs. Until HHS creates a more level playing field between these different types of providers, physical therapists will be unable to meaningfully participate in Medicare and Medicaid APMs, despite their desire to do so, potentially impeding patient freedom of choice and access to the highest quality of care.

APTA firmly believes that physical therapists are central to the quality of care throughout the health care continuum. Physical therapists work cohesively as members of the health care team to ensure the success of innovative delivery models such as bundled payments, accountable care organizations, and other APMs, providing patient care that is critical to improving function and successfully transitioning patients from one setting to the next. For these reasons, we remain steadfast in our efforts to work with Congress and the Administration to craft appropriate laws and regulations that support and foster collaboration between physicians and nonphysician providers in these models. **For these reasons, APTA supports the Administration's overall transition toward value-based care, and we urge Congress to maintain the essential protections afforded by the Stark Law to prevent referral for services that are influenced by financial gain instead of patient health.**

Please consider our recommendations below on the modernization of the Stark Law.

Revisions to the Stark Law

APTA recognizes the need to modify the Stark Law to enable value-based care arrangements that coordinate care, improve quality, and reduce unnecessary costs. However, it is important to ensure that these arrangements do not pose a risk of program or patient abuse. We have concerns that modifications to the self-referral law could potentially result in abusive financial arrangements that may skew incentives. Section 1877(b)(4) of the Social Security Act has always required that a permanent regulatory

exception to the physician self-referral law be established only when it is clear that the exception can pose "no risk of program or patient abuse." **APTA encourages Congress to continue to apply this standard as it considers reforms to the law.**

Promote Participation of Physical Therapists in Value-Based Care Models
The Stark Law is an important tool to protect patients and the federal health care programs from fraud, improper referral payments, unnecessary utilization, underutilization, and other harms. However, the law has been recognized as impeding the development of integrated-care models. While we understand the need to reexamine the applicability of this law to value-based care models, **we strongly urge Congress to establish bright-line safeguards that ensure a fair balance between encouragement of independent physical therapists and other nonphysician provider involvement and prohibiting the proliferation of physician-owned physical therapy services that may incentivize physicians to exclude certain classes of providers and/or suppliers from participating in value-based care models.** Such exclusions seriously compromise patient freedom of choice and access to quality care, and the decision to include physical therapists and other nonphysician providers as meaningful participants within value-based care models should not be clouded by conflicts of interests and financial motivations.

Strengthen the In-Office Ancillary Services Exception
One of the biggest loopholes that result in abusive financing arrangements that are created solely for profit without regard to the best interest of the Medicare beneficiary is the in-office ancillary services (IOAS) exception of the Stark Law. In previous comments to Congress as well as to HHS and CMS, APTA has strongly advocated for the removal of physical therapy as a designated health service permissible under the IAOS exception. As Congress moves to increase flexibility and explore additional exceptions under the Stark Law, **APTA again recommends the establishment of meaningful protections to ensure that the original intent of the law remains intact.**

The IOAS exception is intended to improve coordination of care and promote patient convenience by allowing physicians to self-refer for designated health services integral to primary care that are furnished in their group practices. APTA has significant concerns, however, that the current use of this exception goes well beyond its original intent, specifically in regards to physical therapy. While including physical therapy in the IOAS exception list was intended to offer convenience to patients, it is incredibly rare for a patient to receive physical therapy services during a regularly scheduled physician visit. Instead, the patient makes an appointment subsequent to the physician visit.

The IOAS exception allows physician practices to legally own a practice with multiple satellite offices that furnish physical therapy services without the physician on site. These physicians are able to refer patients to these satellite offices and bill Medicare for the services furnished to them. Unfortunately, physician self-referral of ancillary services creates incentives to increase volume under Medicare's current payment system, resulting in overutilization. And as previously acknowledged by Medicare Payment Advisory Commission (MedPAC), there has been a significant increase in physician ownership of

entities that provide physical therapy. Moreover, there is an inherent financial conflict created by physician ownership of health care businesses to which they refer.
Care furnished under the IOAS exception is often degraded, raising serious quality concerns. Research has shown that patients receive higher-quality care—and therefore better outcomes—when self-referral is not involved. A study on low back pain episodes of care, published in the July 2015 issue of the *Forum for Health Economics and Policies* by Jean Mitchell, PhD, of Georgetown University, found that non-self-referred episodes of care were far more likely to provide “active,” or hands-on, services than self-referral episodes—52% compared with 36%. This, according to the study’s authors, suggests the care delivered by physical therapists in non-self-referred episodes is more tailored to promote patient independence and a return to performing routine activities without pain. It is important to note that “passive” treatments, which are more likely found in self-referring episodes, can be performed by a person who is not a licensed physical therapist. The authors of this paper also cite evidence that these passive physical therapy modalities are “ineffective” in treating low back pain.

Of note, the *Health Economics* study highlights the difference in overall expenditures for episodes of care between self-referring and non-self-referring physicians. The study examines the total insurer-allowed amounts for low back pain episodes of care and parses out expenditures on physical therapy only. On average, spending for services by self-referring providers was $144 as opposed to only $73 for services by non-self-referring providers. This is a significant difference for a very common episode of care. Even more, when the expenditures for the entire episode of care are calculated—not just physical therapy but all care for the episode—self-referral episodes averaged $889 compared with only $602 for non-self-referral episodes. The implication is clear: not only is this a problem for physical therapy, it has spread far beyond.

Another study, published in 2016 in *Health Services Research,* also by Jean Mitchell examines the use of physical therapy following total knee replacement surgery. This study, which mirrors findings of the first, shows that patients treated by physicians with a financial self-interest in follow-up therapy receive less active, hands-on, and one-on-one care than do patients who are treated by physicians who have no financial interest in the follow-up therapy. The incentive exists to extend care for more visits while billing less intensive therapy codes that do not necessarily expedite patient recovery.

The IOAS exception has been inappropriately applied to physical therapy services, which are not same-day services and *should* be subject to the Stark Law’s cornerstone protections.

Allowing physicians to self-refer to physical therapy services intended to reduce burden on patients has instead led to inappropriate utilization of such services. There is no prevailing quality of care need or added patient convenience realized by including physical therapy as a designated health services under the IOAS exception. This has resulted in increased financial gain for physician-owned practices while creating higher costs to patients by limiting patient choice.[1] Thus, rather than expand this exception to apply to additional ancillary services, **we recommend that Congress take steps to tighten the IOAS exception to better ensure more appropriate use of ancillary**

[1] US Government Accountability Office (2014, April). Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries by Fewer Services per Beneficiary (Publication No. GAO 14-270). https:/www.gao.gov/assets/670/662860.pdf Accessed July 19, 2018.

services, including physical therapy. Physician referral to a health care entity in which the physician has an ownership or financial interest creates potential to inappropriately influence medical decision-making, presents an inherent financial incentive to refer, and limits the beneficiary's right to choose his or health care provider. As Congress explores legislation aimed to reduce restrictions on certain physician arrangements in value-based care models, **we strongly encourage Congress to take steps to narrow the scope of the IOAS exception by removing physical therapy from the list of designated health services covered by the exception.**

Ensure That Patient Choice Is Protected

We caution against the creation of exceptions to the Stark Law that are overly broad and pose a risk of program and patient abuse. **Therefore, we recommend that Congress evaluate the existing Stark Law exceptions to ensure that they do, in fact, protect patients' choice and protect against abuse of the Medicare program by physicians who refer patients to services for their own financial gain**. **Further, Congress should encourage HHS to tailor new or existing exceptions specifically for arrangements formed within value-based care models. Any reform to the Stark Law must be narrowly tailored to achieve the desired result of increased flexibility for value-based care, while upholding the key protections afforded by the original law**.

APTA commends the committee for leading this hearing on driving health care delivery toward a value-based payment model and away from the traditional fee-for-service model. APTA is eager to work with members of Congress and HHS to explore policies that will enhance collaboration among physical therapists and physicians in value-based care models. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration of these comments from APTA.