

*Rising Up Against
POPTS...A Time to
Respond*
Academic Administrators, APTA

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Today's Program

- Course Objectives
 - Review history of POPTS; Stark I & II
 - Discuss the history of professional autonomy
 - Consider cultural & structural barriers to autonomy
 - Describe the current POPTS crisis and APTA's strategic plan on POPTS
 - Illustrate APTA's business strategies to combat POPTS
 - Actions you can take

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APTA's POPTS Task Force

- Fran Welk, PT, DPT, MEd – Chair (PA)
- Cynthia Driskell, PT, GCS (AZ)
- Kathleen Luedtke-Hoffman, PT, PhD, MBA (TX)
- Peter McMEnamin, PT, MS, OCS (IL)
- Robert Rowe, PT (LA)
- Paul Slocum, PT (PA)
- Patrick Van Beveren, PT, DPT, (NY)
- Michael Weinper, PT, MPH (CA)

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APTA Support Staff to Task Force on POPTS

- Jack Bennett, Esq.
- Justin Elliott
- Jody Gandy
- Gayle Lee, Esq.
- Frank Mallon
- Dave Mason
- Justin Moore, PT
- Alexis Waters

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History of POPTS

- No one knows when it started, but probably before any of us started practice.
- Came to light in 1976 – 77 in “Letters to the Editor” of *Physical Therapy* from Donald Hiltz, RPT
- Resulted in editor writing an essay on ownership/ control of PT services

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Hiltz Letters

“More and more physicians, particularly orthopedic surgeons are hiring PTs. This trend represents a threat to the entire profession to which we must address ourselves. At best, it is prostitution in which PTs allow themselves to be used for someone else’s profit. At worst, it is tantamount to fee splitting or kickbacks” PHYSICAL THERAPY Vol. 56 No 7 August 1976

“One more year has passed...four more orthopedic surgeons in my geographic area have decided to hire their ‘own’ therapists. The death knell may well be sounding for small independent practitioners like me...if the profession were to establish an ‘Ostrich of the Year’ award, those PTs who continue to function as employees of physicians must be placed in prime contention for that honor” PHYSICAL THERAPY Vol. 57 No 9 September 1977

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POPTS in APTA History

- **1983:** Adopted resolution opposing referral for profit.
- **1987:** FTC investigations of APTA & Components
- **1991:** Reaffirmed position against POPTS (HOD 06-91-15-18).
- **1999:** APTA opposes “overutilization or underutilization, and participation in services linked to financial gain of referral source.”
- **1999:** Vision 2020, APTA BOD and HOD.

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POPTS in APTA History

- **2001-02:** HOD Position on Ownership
- **2002:** PPS Task Force on Physician Self Referral formed
- **2003:** HOD: Strategies to Prohibit POPTS! **Unanimous vote!**
- **2003:** APTA POPTS Task Force following HOD action
- **2004:** Resource Manual on POPTS
- **2005:** SC ruling favors PTs

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Stark I & II

- Stark I (Federal self-referral law) was enacted in 1989 and effective for 1992
- Only applied to clinical labs
- 1993 amendments (Medicare overhaul) added ancillary services; known as Stark II
- Stark II became effective 1/1/95
- But...in 1994, Congress control shifted to Republicans and...

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Stark History

- Legislation started in '95 to pare back Stark II.
- Medicare legislation passed House and Senate yet Clinton vetoed
- Not until 1998 were implementing regs. proposed
- Physicians made big stink
- HCFA bifurcated regs into 2 phases in 2001

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Stark II History

- Phase I
 - Key definitions
 - Group practice situations
 - Exceptions protecting ownership and compensation relationships (roadmap for POPTS)
- Phase II
 - Exceptions relating only to compensation relationships and ownership interests
 - Effective July 26, 2004

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Reactions to Stark Regs

- APTA voiced opposition
- AMA hailed changes as did many medical specialty societies
- Result has been POPTS reborn!
- Today...Docs see no barrier to opening POPTS

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So...Why Do POPTS Exist?

- Stark II liberalized self-referral laws
- PTs don't always perceive themselves as autonomous
- Payers haven't wanted to bark at the POPTS cat in the tree!

- What if...it were illegal to work for physicians???

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Autonomy in Physical Therapy

1. Unique body of knowledge (1920s).
2. Autonomous professional association (1922).
3. Code of Ethics (1922).
4. Autonomous accreditation of professional training (CAPTE 1951).
5. Licensure in 50 states (vs. "registration") (1950s-60s).

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Autonomy in Physical Therapy

6. Defined scope and standard of practice (1990s) .
7. Liability for professional judgment.
8. **Control of Practice** → **"Autonomous Practice"**
 - Direct Access
 - Intellectual "Ownership"
 - Business Ownership of Practice
9. **Autonomous Profession: 2020**

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"Autonomous Practice" vs.
"Autonomous Profession"

"Autonomous Practice"

- Included in Vision 2020
- Individual practice.
- Micro level
- Professionalism and ethical neutrality of individual P.T.
- **Domain:** Fiduciary relationship of professional to patient.
- Accountability of individual practitioner to patient and to Licensing Board.

"Autonomous Profession"

- **Not** included in Vision 2020
- Profession as a whole.
- Macro level.
- Profession's commitment to ethics and regulation of ownership.
- **Domain:** Association protects the autonomy of the profession by fostering the necessary social, economic and legal infrastructure. Protects public by banning conflict of interest to protect "fiduciary duty".
- Accountability of profession to its members, society, legislature.

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Remember!

Autonomous practice
**for the individual physical therapist
cannot survive without the
required social-political-economic-
business infrastructure
supported by an
autonomous profession!**

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Historic Culture of
Physical Therapy Profession

- History of employees- not self-employed, not autonomous
- PT history: gender-based professional glass ceiling
- Struggle for professional recognition
- Reliance on referral
- Autonomy earned, fought for, not inherited—but still limited!
- P.T. altruistic culture avoids 'self-interest'
- Lacking self-interest, susceptible to external exploitation.

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Types of Ownership in PT

1. Physical Therapist owned
2. **POPTS**
3. Lay-owned, privately held
4. Lay-owned, publicly held (HealthSouth)
5. Not for profit / institutional (Easter Seals)
6. Hospital-owned
7. Hybrids: Mixed owners, joint ventures

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POPTS Models

- Physicians employ PTs in their medical practice to provide PT
- Physicians contract with individual PT
- Physicians use POPTS management company or leased employee arrangement:
 - Non-PT-owned POPTS management company
 - PT-owned POPTS management company
- “Incident-to” practice by physicians using either licensed or non-licensed personnel

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Employed therapist’s question...

“So, anyway...
what’s the difference whether I’m
employed by a PT Private Practice,
or employed by a POPTS?...”

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The Problem with POPTS

- Blocks patients from direct access to physical therapist professional expertise, judgment, and opinion
- Interferes with independent clinical judgment of practicing PTs
- POPTS “cherry-pick” patients
- POPTS cherry-pick physical therapists causing staffing shortages elsewhere
- Unfair competition of POPTS harms and exploits community healthcare facilities such as hospitals

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Scope of POPTS Problem

- We know it is huge & growing
- PPS survey results, Nov. 2003
- OIG data soon?
- Evidence of effects of POPTS is strong:
 - Closed PT offices
 - Hospital hiring problems and laying of staff
 - Higher incidence/cost of PT care

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Cost Containment Studies

- FL HC Cost Containment Board studied JVs
 - POPTS provided 43% more visits than non-POPTS
 - POPTS generated 31% more revenue per patient than non-POPTS
- Center for Health Policy Studies (CHPS)
 - 1991 study in FL determined cost impact of \$10.9 million

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Cost Containment Studies

- Wm. M. Mercer study in CA of WC
 - WC patients seen by docs with POPTS were referred to POPTS 66% of time
 - WC patients seen by docs without POPTS were referred 32% of time
 - Resulted in \$233 million of services per year for economic rather than clinical reasons
- Congressional Budget Office 1993 projection
 - Medicare could save \$350 million over 5 years from expanding self-referral ban

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Cost Containment Studies

- OIG of HHS 1994
 - 4 of 5 cases reimbursed for PT in POPTS do not represent true PT
 - \$47 million was inappropriately paid in 1991

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The Problem with POPTS

- Puts PT profession under control of others whose goals & interests are different
- Blocks upward mobility of physical therapists
- Hinders the development of the profession(al)
- Permits economic exploitation of physical therapy at the expense of patients and PTs
- Drains re-investment out of PT profession
- Results in higher health care costs → higher insurance costs for all

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APTA's Strategic Plan to Address POPTS

- Goal I- Educate and increase the awareness of physical therapists regarding the importance of the autonomy of the profession across all practice settings
- Goal II- Develop evidence of the harmful effects of POPTS arrangements
- Goal III- Identify and implement opportunities for joint activities with other health care providers

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APTA's Strategic Plan to Address POPTS

- Goal IV- Educate the public and key opinion shapers on the harmful effects of POPTS
- Goal V- Promote and implement statutory changes to prevent physician ownership of PT services

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Goal I- Educate and increase the awareness of physical therapists regarding the importance of the autonomy of the profession across all practice settings

- Objective 1- develop and distribute educational material to physical therapists on the harmful effects of POPTS in all practice settings
- Objective 2- develop activities and projects that convey the message that POPTS is the antithesis of APTA's Vision 2020

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Goal I- Educate and increase the awareness of physical therapists regarding the importance of the autonomy of the profession across all practice settings

- Objective 3- create and promote educational resources related to POPTS for PT program administrators, educators, and students
- Objective 4- develop and distribute outreach materials for physical therapists currently employed in POPTS settings

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Goal II- Develop evidence of the harmful effects of POPTS arrangements

- Objective 1- to continue to define the impact of POPTS on a variety of physical therapy practice settings
- Objective 2- design and distribute data collection instruments to Chapters for improved data collection on POPTS related experiences of PTs and patients

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Goal III- Identify and implement opportunities for joint activities with other health care providers

- Objective 1- initiate outreach to and discussion with other health care providers who are experiencing encroachment by physician owned services
- Objective 2- coordinate with state Chapters on local outreach activities with other health care providers

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Goal IV- Educate the public and key opinion shapers on the harmful effects of POPTS

- Objective 1- Develop resources and initiate focused activities to inform the public, the press, and other key and opinion shapers about POPTS and referral for profit arrangements

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Goal V- Promote and implement statutory changes to prevent physician ownership of PT services

- Objective 1- coordinate with APTA. Chapters in a focused review of state corporate and professional acts
- Objective 2- seek opportunities to increase federal requirements that apply to Physician owned physical therapy services

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Goal V- Promote and implement statutory changes to prevent physician ownership of PT services

- Objective -3 promote an implement state statutory and regulatory model language and options to prevent physician ownership of PT services
- Objective 4- Develop guidelines and resource materials for efficient and effective operation of component leadership and task forces related to POPTS prohibitions

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Getting involved in POPTS issues at the State level.

- Most POPTS “action” will be at the State level.
- Word has gotten out that PTs are moving on this issue.
- Many Chapters are organizing POPTS task forces and need smart and savvy people to get involved.
- Help your chapter develop an overall strategic plan to achieve professional autonomy in your state—including POPTS regulation.

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POPTS Prohibition Strategies

- **The Delaware Model**
 - Include “wages” in traditional fee-splitting prohibition.
 - Enforcement is on PTs.
 - Emulated by South Carolina.

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SC: PT Practice Act Example of inserting “wages” as strategy

- **Section 40-1-110**
[The South Carolina Board of Physical Therapy Examiners, ...may restrict or refuse to grant a license... and may suspend, revoke, or otherwise restrict the license of a licensed person who:...]

(1) requests, receives, participates, or engages directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services or profits by means of a credit or other valuable consideration including, but not limited to, **wages**, an unearned commission, discount, or gratuity with a person who referred a patient, or with a relative or business associate of the referring person;

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Other State's Legislation

- CO- Corp. practice
- IN- Referral disclosure
- MO- Repeal of anti-POPTS language; replace with disclosure language
- NV- phase out of discipline for employment by physician
- NH- Disclosure of ownership

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Questions to Ask of Clinical Affiliation Sites

- When you receive physician referrals, where do they come?
- In general, what percentage of your patient referrals come from any one physician?
- In the case of a private practice, who owns your facility?

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What's Available Now?

- Resource Manual on POPTS
- Two APTA brochures
 - "Referral for Profit and PT"
 - "A Guide to Surviving POPTS"
- POPTS White Paper
- This presentation as a resource

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What's on the Horizon

- Educational modules to be used by schools to educate students on history and detriments of POPTS ...more detailed than this presentation
- Speakers ? Perhaps coordinated by PPS

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For Further Information...

- Contact APTA's Government Affairs Department

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