Testimony Re: HB 2159
House Health and Human Services Committee

January 23, 2012

Madam Chair and Members of the Committee,

Thank you for allowing me to speak today. I am Mark Dwyer, a Physical Therapist, and I am in support of HB 2159. I have practiced as a physical therapist since 1987 and have worked in multiple settings, including inpatient hospital, outpatient, skilled nursing facility, inpatient rehabilitation facility, and work hardening/industrial rehabilitation.

I support HB 2159 because this bill would allow patients to self-refer themselves to physical therapists if/when the patient chooses to do so. It still requires the PT to send to the physician a copy of the evaluation within 5 working days, and it requires the PT to secure a physician referral should the patient or PT want to continue PT treatment beyond forty-five (45) days.

There are already seventeen (17) states that have complete unrestricted patient self-referral to physical therapy, which allows patients full access, without any restrictions to physical therapy services. **This is not a new policy**, as the majority of these states instituted patient self-referral 20-30 years ago! Listed below are those states along with the year their unrestricted patient self-referral was enacted. If you do the math you will see that the United States already has a combined ***453 years*** of experience with unrestricted patient self-referral to physical therapy services.

Alaska – 1986
Arizona – 1983
Colorado – 1988
Hawaii – 2010
Idaho – 1987
Iowa – 1988
Kentucky – 1987
Maryland – 1979
Massachusetts – 1982
Montana – 1987
Nebraska – 1957
Nevada – 1985
North Dakota – 1989
South Dakota – 1986
Utah – 1985
Vermont – 1988
West Virginia – 1984

Our opponents will state they have safety concerns regarding patient self-referral to PT services. However, in those states with complete unrestricted patient self-referral to PT services there is no record of a safety problem, and in none of the states have those laws been repealed. To our knowledge, there has never even been any action taken to try to repeal these laws by any physician group or any other group. One would think that if patient self-referral to physical therapy was such a safety risk, groups would be trying to repeal it and legislatures would be taking action. Yet there has been no activity of that kind in any of those states.

The Kansas Health Institute article[1] titled, "Collaborative Efforts Can Save Money and Improve Care" that is included in my "Supporting Documents" demonstrates the cost saving power of providing businesses, insurers, and patients a choice in their providers. As the article states, "Rather than waiting to see a doctor, Cady and other patients with routine back pain now see a physical therapist within 48 hours of calling, compared with about 19 days previously, Intel says. They complete their treatment in 21 days, compared with 52 days in the past. The cost per patient has dropped 10 percent to 30 percent due to fewer unnecessary doctor visits and diagnostic imaging tests. And patients are more satisfied and return to work faster." This came about because of "an unusual collaboration between Intel, two local health care systems, and a health insurer." Also note that nowhere in this article is there any mention of patient harm as a result of seeing physical therapists first.

There is a more interesting aspect to this article, however. **It's that under current State law we could not create that type of program here in Kansas.** While Oregon does not have complete unrestricted patient self-referral to PT services, their self-referral provisions are nearly the same as what HB 2159 would allow in Kansas (60 days in Oregon versus 45 in Kansas). By passing HB 2159 you would allow Kansas employers, insurers, and patients the opportunity to establish these collaborative programs that will provide high quality care while at the same time **lowering costs** for everyone involved.

To further demonstrate the cost savings that patient self-referral can generate, see the recently published study in Health Services Research (abstract is included in my "Supporting Documents") that documents these results, "Self-referred episodes had fewer PT visits (86% of physician referred) and lower allowable amounts ($0.87 for every $1.00)". See the table below for the differences found between self-referred PT episodes of care compared to physician referred episodes of care.

	SELF-REFERRED	PHYSICIAN REFERRED
Average Age	43.6	45.9
Average visits per episode	5.9	7.0
Allowable amount per episode	$347	$420

The data above represent a 16% *reduction* in visits and a 17% *reduction* in the cost of care.

Lowering costs is important in today's system since changes that have occurred in insurance coverage over the last ten years is placing more of the financial responsibility for care on the patient. **Because of that, it is now more important than ever to provide patients more choice in the health care services they receive**. Many employers and insurance companies have embraced consumer directed health plans that put more of the financial responsibility on the shoulders of the patients. These involve medical savings accounts tied to high deductible health insurance plans. Even "regular" insurance plans are now instituting high deductibles, as high as $3,000, $4,000, and even over $5,000, along with high co-pays and 20% or higher co-insurance.

The theory behind putting more of the cost burden on the patient is that it will force patients to be active participants in their health care and create incentives for patients to choose more carefully when to receive care and who to receive it from so as to reduce cost. However, the only way in which this can be an effective long-term strategy for the American and Kansas health care systems is **if patients can actually exercise those choices** in what health care to seek out and who to receive it from.

It's not as if patients are alone is wanting to exercise these choices. Employers, insurance companies, and even some government payors are designing coverage packages that specifically

[1] http://www.khi.org/news/2012/jan/06/collaborative-efforts-can-save-money-and-improve-c/

place this decision making responsibility on the patient, but what good is it is the patient cannot make those decisions because State law precludes them from doing so?

Those changes are having the desired effect, too, as demonstrated in the just released CMS "National Health Expenditure Data"[2] report. In that report it states, "U.S. health care spending grew 3.9 percent following record slow growth of 3.8 percent in 2009; the two slowest rates of growth in the fifty-one year history of the National Health Expenditure Accounts". That is great news in that we are slowing health care spending in the U.S.! This report attributes some of this slowing to "higher cost-sharing requirements for some employers," which is what I describe above in that patients are taking on more of the cost responsibility for their care. Interestingly, it also goes on to attribute some of the cause of the slower growth to "a decline in private health insurance enrollment", which places ALL of the health care cost burden on the patient.

In light of the fact that our health care system seeks to put more of the financial responsibility on the patient, AND that it's actually working to reduce the growth in health care spending, **the patient has to be given the CHOICE of where to receive that care**. In the seventeen states listed above, patients can exercise their right to see a PT should they choose to do so, and it is clear that there is not a safety issue in those states. In Kansas we cannot access PTs when we want to, and you cannot either, even if you pay for it out of pocket. This is costing Kansas businesses, insurers, and patients more than it is in those states that allow patient self-referral to PT services.

As a result of this overwhelming evidence favoring patient self-referral to physical therapists, I ask that you pass HB 2159 so as to allow the citizens, employers, and insurers in Kansas the same ability to access physical therapist services as our neighbors enjoy in Iowa, Nebraska, and Colorado, and that led to significant cost savings at Intel in Oregon.

Thank you for permitting me to testify. I welcome any questions you may have for me.

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[2] https://www.cms.gov/nationalhealthexpenddata/

SUPPORTING DOCUMENTATION

Wellmark Blue Cross and Blue Shield 2008 Pilot Program

The Wellmark Blue Cross and Blue Shield 2008 pilot program, a quality improvement program for Iowa and South Dakota physical medicine providers, collected data from 238 physical therapists, occupational therapists, and chiropractors who provided care to 5,500 Wellmark members with musculoskeletal disorders.

The data showed that 89% of the Wellmark members treated in the pilot reported a greater than 30% improvement in 30 days. In addition, Wellmark claims data for members who received care from physical therapists or chiropractors was compared with data for a member population with similar demographics (including health) who did not receive such services. The comparison showed that those who received physical therapy or chiropractic care were less likely to have surgery and experienced lower total health care costs.

From the CMS National Health Expenditures 2010 Report

"**Out-of-Pocket:** Out-of-pocket spending grew 1.8 percent in 2010, an acceleration from growth of 0.2 percent in 2009. Faster growth in 2010 partially reflects higher cost-sharing requirements for some employers, consumers' switching to plans with lower premiums and higher deductibles and/or copayments, and the continued loss of health insurance coverage."
https://www.cms.gov/NationalHealthExpendData

HSR Health Services Research

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RESEARCH ARTICLE

A Comparison of Health Care Use for Physician-Referred and Self-Referred Episodes of Outpatient Physical Therapy

Jane Pendergast, Stephanie A. Kliethermes, Janet K. Freburger, and Pamela A. Duffy

Objective. To compare patient profiles and health care use for physician-referred and self-referred episodes of outpatient physical therapy (PT).

Data Source. Five years (2003–2007) of private health insurance claims data, from a Midwest insurer, on beneficiaries aged 18–64.

Study Design. Retrospective analyses of health care use of physician-referred ($N = 45{,}210$) and self-referred ($N = 17{,}497$) ambulatory PT episodes of care was conducted, adjusting for age, gender, diagnosis, case mix, and year.

Data Collection/Extraction. Physical therapy episodes began with the physical therapist initial evaluation and ended on the last date of service before 60 days of no further visits. Episodes were classified as physician-referred if the patient had a physician claim from a reasonable referral source in the 30 days before the start of PT.

Principal Findings. The self-referred group was slightly younger, but the two groups were very similar in regard to diagnosis and case mix. Self-referred episodes had fewer PT visits (86 percent of physician-referred) and lower allowable amounts ($0.87 for every $1.00), after covariate adjustment, but did not differ in related health care utilization after PT.

Conclusions. Health care use during PT episodes was lower for those who self-referred, after adjusting for key variables, but did not differ after the PT episode.

Key Words. Access to care, physical therapy, physician referral, direct access

Collaborative efforts can save money and improve care

By Harris Meyer / KHN News Service. Jan. 6, 2012

Peter Cady and other patients with back pain can see a physical therapist within 48 hours, rather than having to wait weeks for a doctor.

HILLSBORO, Ore. — Peter Cady, who works 12-hour shifts on his feet at Intel's plant here, occasionally suffers severe lower back spasms. But he nearly gave up seeking medical help because in the weeks it took to get a doctor's appointment and a referral to physical therapy, the pain usually subsided.

These days, however, Cady is much happier with his care.

Rather than waiting to see a doctor, Cady and other patients with routine back pain now see a physical therapist within 48 hours of calling, compared with about 19 days previously, Intel says. They complete their treatment in 21 days, compared with 52 days in the past. The cost per patient has dropped 10 percent to 30 percent due to fewer unnecessary doctor visits and diagnostic imaging tests. And patients are more satisfied and return to work faster.

"It's a real bureaucracy buster that gets you right straight to someone who can take care of the problem," says Cady, 47. "Before, the doctor wasn't helping me or explaining anything. But the physical therapist educated me, gave me stretches and exercises to do, and cleared it up."

The change came about through an unusual collaboration between Intel, two local health care systems, and a health insurer. Based on that success, the partners have developed similar improvements for hip, knee, shoulder and headache treatment. Intel and its partners say the result has been $2 million in administrative savings this year, from reduced costs for patient scheduling and registration, for example.

The Hillsboro collaboration is one of a small but growing number of voluntary partnerships around the country to tackle the twin problems of unsatisfactory quality and rising health-care costs. Similar programs are underway in Atlantic City, N.J.; Lewiston, Maine; Muskegon, Mich.; Sacramento, Calif.; San Francisco and Seattle. One is budding in Orlando.

All the efforts draw on quality improvement models developed in manufacturing and other industries. Physicians and hospitals share cost savings with the employers and insurers, and in some cases share losses if savings targets aren't met. Medicare has launched a similar program under the 2010 health reform law aimed at developing so-called accountable care organizations.

Tackling a cost crisis

Experts say employers, hospitals, physicians and health plans increasingly are willing to work together because cost and quality problems have reached crisis levels. The goal is to carve out health-care spending that's wasteful and doesn't help patients. Sometimes there's an implicit threat that if a provider or health plan doesn't participate, the large employer will buy health care from someone else.

"It all starts when leaders in a community say the current system is not sustainable and we've got to find a different model," says Joe Damore, a vice president at Premier, a national alliance of 200 health systems focused on performance improvement. "Major employers are jumping on board because they see it as an opportunity to improve their employees' health and reduce costs."

Intel asked Providence Health & Services, Tuality Healthcare and Cigna to collaborate in 2009 because its employee health costs were rising by more than 10 percent a year, with costs projected to hit $1 billion companywide. The Oregon Public Employees' Benefit Board recently joined the effort, having its members participate in the redesigned Providence and Tuality care models, sharing its data with the collaborative, and working with the partners to come up with new ways of improving quality and reducing costs.

"Health care was the only area where we weren't setting standards and managing our suppliers," says Patricia McDonald, an Intel vice president who spearheaded the project. "Our employees were waiting for care and the quality was questionable."

In Atlantic City, Unite Here Health, a hotel workers' union health plan, persuaded AtlantiCare, a local health care system, to open a special, jointly funded clinic (PDF) in 2007 to provide intensive outpatient care to high-cost patients with chronic conditions such as diabetes, obesity and heart disease. The program, which the union is replicating in Las Vegas, achieved steep drops in patient smoking, blood pressure and diabetic blood sugar levels, according to AtlantiCare. By keeping patients healthier, it has reduced hospital admissions by 41 percent and emergency department visits by 48 percent.

Collaboratives help physicians and hospital leaders see employers and patients as customers whose expectations, such as rapid access to care, must be met. "I practiced for 30 years without knowing how long patients waited to see me," says Dr. Robert Mecklenburg, who led the development of a collaborative effort at Virginia Mason Medical Center in Seattle, which started working with Starbucks and other employers in 2004. After meeting with employers, he adds, "you realize how important it is to see patients when they need to be seen. Any wait is not OK."

Roadblocks to collaboration

There are still many obstacles to such partnerships. It's often difficult to get traditional competitors and antagonists to collaborate, including sharing proprietary medical and financial data. Some employers are reluctant to get directly involved in how health care is delivered. Critics warn about rationing of care. And some physicians complain about interference with their professional autonomy, although Mecklenburg says most come around when they see better results for patients.

Perhaps the biggest roadblock is the predominant fee-for-service system, which pays providers to deliver more

services, rather than better, more efficient care. Health-care payers, including private insurers and Medicare, have been slow to change their payment models to reward outcomes rather than volume of care. That sometimes puts providers in the position of losing revenue by doing the right thing for patients.

Dr. Donald Storey, who worked on the Seattle collaborative as an Aetna medical director and now is a vice president at Premera Blue Cross, blames insurers' reluctance to change on their having many different contracts with employers and providers. In addition, not everyone wants a more efficient system. "One man's waste is another man's income," he says.

Some insurers have embraced collaboration. In Sacramento, Blue Shield of California, Catholic Healthcare West and Hill Physicians Medical Group have worked with CalPERS, the state public employee benefit system, to redesign care after they identified quality problems and high costs for 42,000 plan members.

Key areas were obesity-reduction surgery, hip and knee care, hysterectomies, and preventable emergency department visits and hospital readmissions. For example, Hill Physicians persuaded its OB/GYNs to perform more minimally invasive hysterectomies, which are safer and cheaper than open hysterectomies, when appropriate. Catholic Healthcare West hospital staff worked closely with patients on their medication instructions before discharge, to make readmissions less likely.

Redesigning care through a collaborative is "not easy to do. There's a lot of investment of human resources, and we didn't know if it would work or not," says John Wray, senior vice president for managed care at Catholic Healthcare West. "But this was something we thought was important to try to learn from."

It worked. Hospital length of stay and readmissions both declined 15 percent in 2010. That helped save more than $20 million, exceeding the $15.5 million target and allowing Blue Shield to keep CalPERS' premiums flat in Sacramento for 2011. The remaining savings were split among the three partners, who would have lost money if the target hadn't been hit.

Now Blue Shield is working with its current partners and several additional provider organizations to improve care for 26,000 members of the San Francisco public employee plan. It's also starting partnerships in January for 38,000 plan members in California's Orange and Stanislaus counties.

Mecklenburg hopes this partnership model will spread widely across the country. "We are creating a marketplace based on quality, where employers can use their purchasing power to bring out the best in both providers and health plans," he says. "But up to now it hasn't usually worked that way."

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