Example of Conversation with Member of Congress regarding H.R. 4204, the Medicare Patient Choice Act

PT Advocate: Hi Congresswoman/man [last name], thank you for taking time out of your busy schedule to meet with me today. My name is [first and last name] and I'm a PT who lives in your district. I own a therapy practice called [practice name], and it's located in [name of town], down on [street name in town]. It's a [small/big] clinic, we have [number of] employees, but we have plenty of patients to keep us busy. Sometimes too busy. I know I've been in before to talk about Medicare payment cuts impacting PTs, and the need for Medicare provider payment reform, but today I want to talk about a new bill, H.R. 4204, the Medicare Patient Choice Act.

The bill is led in the House by Representatives Lloyd Smucker and Don Davis. It's a pretty straightforward bill. Back in the Balanced Budget Act of 1997, Congress created a policy to allow health care providers to formally opt out of Medicare and privately contract with Medicare beneficiaries. Physicians and other health care practitioners were included, but PTs and other therapy providers were not. This bill would simply allow physical therapists, occupational therapists, speech-language pathologists, audiologists and chiropractors to be added to the already long list of other health care provider who can privately contract with Medicare beneficiaries.

If this bill were to pass, it would modernize Medicare and increase access to physical therapy, while also allowing private practice owners greater flexibility on how we can run our business. A lot has changed in almost 30 years since this policy was created. We now have many cash-based practices operating across the county. And in case you aren't aware of the term, cash-based just means a provider doesn't accept any insurance, including Medicare. In addition, many practices are short-staffed and have waitlists to see patients. Allowing Medicare beneficiaries a greater access providers to their choice of providers may help prevent delays in care.

These types of cash-based practices already exist, but due to the fact that PTs weren't on the original list in 1997, when a patient has been visiting a cash-based PT clinic for years and may have a very long standing relationship with their PT, once they turn 65 and become a Medicare beneficiary, the PT is forbidden by law to treat them. It's an unintended consequence that has now created a barrier to care for Medicare beneficiaries.

In addition, this bill also saves the government money, which we know Congress always likes to hear. Two years ago, APTA and AOTA hired an outside firm, Dobson & DaVanzo, to conduct a cost analysis. Their report shows that it would save the federal government approximately $140 million over 10 years. But we believe it could save more. When they did the scoring 2 years ago, they used a draft bill that didn't include the audiologists or chiropractors, so adding those two professions, as HR 4204 has, could increase the savings.

Sir/Mam, I would love for you to cosponsor this important legislation. Do you have any questions for me?

Member of Congress: Thank you for the overview of the legislation, I do have a few follow-up questions. You mentioned that other health care providers can already do this. Which providers?

PT Advocate: Currently, MDs/DOs, Dentists, Podiatrists, Optometrists, Physician Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Certified Nurse Midwifes, Clinical Psychologists, Clinical Social Workers, Registered Dietitians, and Nutrition Professionals can formally opt out of Medicare and privately contract with Medicare beneficiaries.

Member of Congress: Thank you, that's helpful. If all of those providers are already allowed, do you know approximately how many of them choose to opt out of Medicare? I'm a little concerned about losing a large amount of providers from our Medicare program.

PT Advocate: Yes, I can understand that concern, but historically the number has always been low. A January 2025 Kaiser Family Foundation article shows that about one percent of all non-pediatric physicians have formally opted out of the Medicare program in 2024. The share was highest for psychiatrists (8.1%), followed by plastic and reconstructive surgeons (4.5%). In addition, as part of the APTA/AOTA cost analysis study two years ago, that analysis showed that only around 1.6% of PTs would choose to opt out of Medicare if enacted.

Member of Congress: That's less than I imagined. If PTs are allowed to opt out, what does that actually mean? What is the process for both the PT and patient?

PT Advocate: In order to opt out, the PT must file an opt-out affidavit with the Medicare Administrative Contractor (MAC). PTs will be held to continuous two-year opt-out periods. Once formally opted out, the PT is forbidden to see any Medicare beneficiary without having them sign a private contract first. These contracts must be kept on file in the PT's office and be available to be sent to the MAC or to CMS upon requested. The Medicare beneficiary will pay the PT directly for all care provided and the PT will not accept any payment from Medicare.

Member of Congress: Thanks, is it true that there is already a process that a cash-based practice could use to not be in Medicare, but still see Medicare patients, I believe it's called being a non-participating provider? How does that process differ that opt out?

PT Advocate: The overall process for being a non-participating provider in Medicare is an administrative burden for the PT and their staff, while also confusing for the Medicare beneficiary.

To become a non-participating Medicare provider, the PT would enroll in Medicare and choose not to sign the participating provider agreement. Doing this would also not include the PT in the Medicare directory as a provider. As a non-participating provider, the PT can choose to accept

assignment for individuals claims (accept Medicare's approved amount as payment in full) or not. When a non-participating Medicare PT accepts the Medicare rate, it is 5% less than what a participating provider receives under the Medicare physician fee schedule.

When a non-participating Medicare PT declines assignment (aka Medicare rate), a PT may charge a Medicare beneficiary up to 15% above what Medicare pays known as a limiting charge. This is in addition to the traditional 20% coinsurance. Some states, like New York, have specific laws that may lower the limiting charge percentage for certain services.

For a PT to collect the maximum amount allowed (again, that is 115% of the Medicare physician fee schedule rate), the Medicare beneficiary would have to pay the entire amount out of pocket. Once the PT files the claim with CMS, the beneficiary would be reimbursed by CMS for the covered amount, which is about 80%.

So, as you can see it's not the easiest process and simply being able to opt out and privately contract with the patient would serve as a better option.

Member of Congress: Thank you, I didn't know how confusing that process was. That was helpful. I apologize for having so many questions, but this discussion really helped me better understand the issue and this legislation. I will consider supporting the Medicare Patient Choice Act.

PT Advocate: Congresswoman/man, thank you for considering cosponsoring the bill. We would really love your support. If you or your staff have any additional questions, please feel free to contact me. And as always, please use me as a resource for any therapy questions you may have.

Thank you for your time today and have a great day.