NARA
The National Association of Rehabilitation Providers and Agencies

July 10, 2024

United States House of Representatives
Ways and Means Committee
Subcommittee on Health
Hearing on Improving Value-Based Care for Patients and Providers

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Dear Chairman Jason Smith and Health Subcommittee Chairman Vern Buchanan,

We thank you for the opportunity to provide our perspective based on the June 26, 2024, Ways & Means Health Subcommittee hearing entitled, "Hearing on Improving Value-Based Care for Patients and Providers".

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapy, occupational therapy and speech-language pathology providers through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities, assisted living facilities, hospital outpatient, hospital inpatient, in the beneficiary's home, and in retirement communities. As a member-driven organization, NARA promotes the growth and business success of physical therapy, occupational therapy, and speech-language pathology providers through education, support, and advocacy. NARA's membership demographics give us a unique insight into payment and quality programs across the full healthcare landscape.

Introduction

NARA members are very supportive of value-based care for patients and providers, and in fact have provided education and opportunities for our members to learn how to effectively transition out of a fee-for-service model of care. Since many of our members work in collaboration with other health care providers it is essential that we understand how to contribute, but also that we have an opportunity to demonstrate the value we can bring to the health care system. This context frames our comments below. First, we discuss opportunities to increase our participation in quality programs and the influence that the stability of the reimbursement system has on our ability to participate. Next, we provide examples of how NARA members could provide solutions to the health care deserts in rural and underserved areas of the country. Finally, we provide evidence that supports the fact

that early referral to rehabilitation services can have real downstream effects through reducing costs and improving healthcare outcomes.

Quality Programs and Reimbursement Stability

We agree with Chairman Buchanan's statement that the fee-for-service (FFS) system is not working, and value-based care is better for the patients and generates savings for public and private payers. Rehabilitation providers are generally considered an ancillary provider, but we work collaboratively with other health care providers such as: primary care physicians, orthopedic surgeons, dentists, physician assistants, nurse practitioners, and podiatrists. The intent of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 was to provide a path to transition from a fee-for-service to a fee-for-value payment system in healthcare. The Merit-Based Incentive Payment System (MIPS) established by MACRA became effective January 1, 2017. MIPS rolled three existing quality and value reporting programs into one program. Eligible Medicare Part B clinicians are scored annually on their participation in 4 categories: Quality, Promoting Interoperability, Improvement Activities and Cost. Clinicians receive a score on a 100-point performance scale which results in a Composite Performance Score (CPS). The CPS is then used to determine a clinician's eligibility for a bonus in a subsequent payment year. Unfortunately, most physical therapists (PT), occupational therapists (OT) and speech-language pathologists (SLP) are excluded from the program. Currently, those therapists who provide outpatient therapy services under Medicare Part B and bill through **rehabilitation agencies, skilled nursing facilities (SNFs), and hospital outpatient departments are unable to participate in MIPS** because they bill on the UB-04 Institutional Claim form (CMS 1450). Per the MedPAC report on outpatient therapy services payment system in November 2021,[1] 61% of therapy spending for Part B services was submitted by providers on the UB-04 (CMS 1450) form. As a result, MIPS applies to less than 39% of Part B therapy providers. **NARA recommends modifying the program to allow the vast majority (61%) of therapy providers to participate in MIPS. This would give access to more providers to participate in value-based care through a mechanism already established by the Centers for Medicare and Medicare Services (CMS).**

Conversely, rehabilitation providers and other providers who bill for services under their own NPI on the CMS 1500 form are eligible to participate in MIPS. Depending on the volume of Medicare FFS services a therapist bills in a 12-month period, they may be deemed a provider who is required to participate or one who can volunteer to participate. Many of these providers find the overall level of effort and cost to participate are not worth the 1-2% potential bonus in their payments. The cost to participate in and comply with MIPS can be significant. According to study from 2019, on average it cost practices nearly $13,000 per physician to participate in MIPS in 2019, with even greater costs incurred by smaller

[1] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opt_final_sec.pdf

practices (Khullar et al. 2021). However, another study found that surgeons participating in the 2021 MIPS performance year found that most surgeons received bonus payments, but they only averaged $1,341 (Maganty et al. 2024) per surgeon. Based on the cost and the payments sited in these two studies, the time and financial costs to participation are not close to being offset by the bonus. The costs to participate include staff time to understand the requirements of the program which change annually, substantial payments to registries to report the quality measures, use of certified electronic health record technology (CEHRT), and provider training to ensure successful reporting. For those therapists deemed to be required to participate but choose not to participate after weighing the return on investment, they become subject to a penalty of up to 9% on their subsequent FFS payments.

Another obstacle many providers, such as rehabilitation providers, experience is the inability to obtain points in the Promoting Interoperability performance category which makes up 25% of the score, as they do not utilize a CEHRT, putting them at greater risk of being penalized. The cost to change EHRs, train providers and back-office staff, and do a major overhaul on current documentation processes is substantial and simply out of reach for most providers. We want to be clear, however, that **NARA supports interoperability and recognizes the value it has in reducing administrative burden** for providers while improving the overall experience for providers and patients. During the hearing, Matthew Philip (Duly Health & Care) testified that value-based care requires a large amount of paperwork undermining the relationship between the provider and the patient and by mitigating data lags, fraud could be prevented, and outcomes improved. We agree with Mr. Philip's statement, but also want to note that there remain significant disparities across provider types as to their ability to utilize interoperable solutions.

An additional barrier to MIPS participation for rehabilitation providers is the lack of applicable quality measures applicable to the rehabilitation specialty. Many of the available quality measures are focused on primary care. However, to successfully report in MIPS, a clinician must choose at least 6 quality measures to report over a 12-month performance period. This has caused rehabilitation providers to "force" quality measures to fit within their practice population or risk a negative adjustment. We believe that while this was likely not the intent of the MIPS system, it has effectively resulted in a significant number of clinicians reporting measures just for the sake of reporting, without meaningfully capturing the value of rehabilitation services. Additionally, the limited number of available quality measures makes it difficult to appropriately compare quality measures across similar clinicians **NARA asks that CMS work with interested parties to identify measurement gaps within the rehabilitation specialty so that more appropriate and meaningful quality measures that are more applicable to rehabilitation providers are adopted into the MIPS program.**

NARA believes any value-based program should include the following core components: (1) a cost savings component; (2) standardized measures across providers and settings; (3) does not require substantial costs to participate; and (4)

provides incentives that justify providers' costs and administrative burden to participate.

Finally**, we recommend Congress direct CMS to analyze MIPS data that has already been collected and share a report with the healthcare industry.** MIPS has been in existence for over 7 years, and yet there has been minimal analysis of the data collected and shared with providers to determine the success of the program. De-identified data should also be made available to providers to perform their own analysis. **NARA supports Ranking Member Lloyd Doggett's comments that we need to define what value means and then ensure providers are collecting the "right" data and analyzing it effectively.** Without analyzing the 7 years of MIPS data, we have no insight into whether it is working as intended to improve the quality and value of care.

In summary, the MIPS system is based on winners and losers in the points system. If rehabilitation providers are unable to achieve 100% of the points, which they are not able to in calendar year 2024 since they earn zero points in the CEHRT category, they have a greater chance of losing and being penalized with a negative payment adjustment. Since rehabilitation providers have seen reimbursement cuts of nearly 30% over the past 10 years and have no relief in sight, another cut makes Medicare beneficiaries' access to these vital services unsustainable.

Some immediate actions Congress can take to support Medicare payment reform in the short term to ensure providers are reimbursed appropriately for the services they provide which will go a long way in maintaining access to care for patients. These are:

- Pass the Strengthening Medicare for Patients and Providers Act (HR 2474) which would modify certain adjustments to payment amounts under the physician fee schedule based on a service's relative value, a conversion factor and a geographic adjustment factor.
- Pass the Physician Fee Schedule Update and Improvements Act (HR 6545) which would enact reforms by extending Medicare payment floor for work geographic index to January 1, 2025; update the budget neutrality threshold from $20 million to $53 million for 2025 and provide an inflationary adjustment for 2030 and every five years thereafter; and update direct costs used to calculation the practice expense relative value at least every five years.
- Pass the Provider Reimbursement Stability Act (HR 6371) which would reform the Medicare Physician Fee Schedule budget neutrality requirements by raising the budget neutrality threshold from $20 million to $53 million and increasing it every five years by the cumulative increase in the Medicare Economic Index; updating practice expense inputs, such as clinical labor costs, at least every five years; and limiting the year-to-year conversion factor variance to no more than 2.5% each year.

- Pass the REDUCE Act (HR 7279) which would clarify a new streamlined model that when outpatient therapy services are provided under a physician's order, the plan of care certification requirement will be deemed satisfied if the qualified therapist simply submits the plan of care to the patient's referring physician within 30 days of the initial evaluation; therapists would no longer need to obtain a signed plan of care within 30 days from the referring physician.

Rural and Unserved Areas

During this hearing, Sarah Chouinard (Main Street Health) noted that there are approximately 85% fewer specialists in rural areas, yet this population is at the biggest risk due to being economically disadvantaged and geographically isolated. This combination frequently leads to these individuals receiving fewer preventative services and delaying care when they do need medical care, which results in a sicker, more chronically ill population. **Rehabilitation providers, NARA members, could help to address these disparities but are often unable to break into these areas due to administrative or regulatory reasons.**

Some immediate actions Congress can take to help reduce this situation is by passing the following bills that have been introduced in the 118th Congress:

- Expanded Telehealth Access Act (HR 3875) which would instruct CMS to permanently adopt the current temporary waiver of restrictions on Medicare payment for services delivered via telehealth by physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, and speech-language pathologists.
- The EMPOWER Act (HR 4878) which would remove the current direct supervision requirement for physical therapist assistants (PTA) and occupational therapy assistants (OTA) providing Medicare Part B services in a private practice setting.
- The SAFE Act (HR 7618) which would ensure that beneficiaries who were identified by their physicians as having experienced a fall in the year prior to their Initial Preventive Physical Examination (Annual Wellness Visit) would be referred to a physical therapist for falls screening and preventive services.
- The Physical Therapist Workforce and Patient Access Act of 2023 (HR 4829) which would allow physical therapists to participate in the National Health Service Corps Loan Repayment Program, helping to ensure that individuals in rural and underserved areas have access to need therapy care.

Early Referral to Rehabilitation Providers Can Save Money

There is evidence to support that early referral to physical therapy results in a lower risk of subsequent medical service utilization among patients after an episode of acute low back

pain relative to those who received physical therapy (PT) at later times[2]. In 2022, a study[3] found early PT groups had lower incidence of advanced imaging, injections, chiropractor visits, orthopedic surgeon & pain specialist visits, and emergency room visits compared with patients who did not receive early PT. This early intervention with PT found that patients spent on average $2,700 less on low back pain-related care than those who received delayed PT during the 18 months after injury[4].

In September 2023, the American Physical Therapy Association (APTA) published the "The Economic Value of Physical Therapy in the United States" which analyzed 8 separate conditions typically treated by physical therapists and physical therapist assistants from knee osteoarthritis to cancer rehabilitation. The result was net savings ranging from $2,144 for falls prevention to $39,533 for carpal tunnel syndrome treatment with the conclusion that these results demonstrate that when medically appropriate, the widespread use of the selected physical therapy services would deliver both health and economic benefits to patients and the United States health care system. These results are not surprising considering physical therapists do not prescribe opioids, order imaging, or treat patients with injections or surgery[5]. This aligns with statements from Chair Vern Buchanan that the U.S. is spending more money, yet we are still sicker than anybody else, and that everyone should be the "CEO of their own health." Physical therapy for musculoskeletal conditions is lower risk and utilizes exercise, manual therapy, and functional activity training as its primary interventions. Additionally, physical therapy and occupational therapy provide education and recommendations for an ongoing healthy lifestyle resulting in significant cost savings for the system and patients.

Some immediate actions Congress can take to ensure early intervention for physical therapy, occupational therapy, and speech-language pathology that will prevent the need for patients to need higher cost services are:

- Pass the SAFE Act (HR 7618) which would ensure that beneficiaries who were identified by their physicians as having experienced a fall in the year prior to their

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[2] Gellhorn AC, Chan L, Martin B, Friedly J. Management patterns in acute low back pain: the role of physical therapy. Spine (Phila Pa 1976). 2012 Apr 20;37(9):775-82. doi: 10.1097/BRS.0b013e3181d79a09. PMID: 21099735; PMCID: PMC3062937.

[3] Marrache, M., Prasad, N., Margalit, A. *et al.* Initial presentation for acute low back pain: is early physical therapy associated with healthcare utilization and spending? A retrospective review of a National Database. *BMC Health Serv Res* **22**, 851 (2022). https://doi.org/10.1186/s12913-022-08255-

[4] Fritz JM, Childs JD, Wainner RS, Flynn TW. Primary care referral of patients with low back pain to physical therapy: impact on future health care utilization and costs. Spine (Phila Pa 1976). 2012;(37):2114–21.

[5] The Economic Value of Physical Therapy in the United States. Available at: https://www.valueofpt.com/

Initial Preventive Physical Examination (Annual Wellness Visit) would be referred to a physical therapist for falls screening and preventive services.

- Pass the Personal Health Investment Today, or PHIT, Act (HR 1582) which would allow a medical care tax deduction for up to $1,000 (or $2,000 for joint return or head of household) of qualified sports and fit expenses per year. This would incentivize patients to be healthier physically.

Conclusion

NARA supports value-based care payment models. However, we strongly believe the model should be inclusive, streamline data collection, and avoid being so cost prohibitive that it limits provider participation. The program must include methods to measure downstream cost and quality measure analysis that promote peer comparison across patient populations and diagnostic groups. Permanent Medicare payment reform should be passed rather than temporary one- or two-year patches. It is challenging for providers to plan and build for the future in operations and patient care when temporary fixes promote uncertainty. Telehealth is a great example of the adverse effect of these patches. It requires an investment in infrastructure that providers hesitate to commit to when access is temporary. Congress and CMS can act now to pass legislation that has been introduced (and listed above) to decrease administrative burden, reform payment and make permanent the ability for rehabilitation providers to deliver telehealth and other innovative programs.

We thank you for the opportunity to provide comments related to this hearing. Should you have any questions concerning these comments, please contact Christie Sheets, NARA Executive Director at christie.sheets@naranet.org.

Respectfully submitted,

Kelly Cooney, M.A., CCC-SLP, CHC
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