

Statement for the Record

House Energy & Commerce Committee  
Subcommittee on Oversight and Investigations

“MACRA Checkup: Assessing Implementation and Challenges that Remain for  
Patients and Doctors.”

Submitted jointly by:

ADVION (formerly National Association for the Support of Long Term Care)  
Alliance for Physical Therapy Quality and Innovation  
American Health Care Association  
American Occupational Therapy Association  
American Physical Therapy Association  
American Speech-Language-Hearing Association  
APTA Private Practice, a section of the American Physical Therapy Association  
Athletico  
National Association of Rehabilitation Providers and Agencies

June 22, 2023

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The Honorable Morgan Griffith, Chair  
House Energy & Commerce Committee  
Subcommittee on Oversight and Investigations  
2125 Rayburn HOB  
Washington, DC 20515

The Honorable Kathy Castor, Ranking Member  
House Energy & Commerce Committee  
Subcommittee on Oversight and Investigations  
2125 Rayburn HOB  
Washington, DC 20515

Dear Chairman Griffith and Ranking Member Castor,

On behalf of the undersigned organizations, we thank you for the opportunity to submit a statement for the record for the hearing entitled “MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors.” Our organizations represent over 560,000 therapy providers providing care across a variety of setting including private practice outpatient therapy clinics, rehabilitation agencies, and skilled nursing facilities.

#### Background

The 2015 Medicare Access and CHIP Reauthorization Act, known as MACRA, replaced the flawed Sustainable Growth Rate formula with the Quality Payment Program, or QPP. The QPP comprises two tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, also known as AAPMs. The Centers for Medicare & Medicaid Services began implementing the QPP in 2017, with the eventual goal of moving providers out of MIPS and into AAPMs. There are a number of foundational issues with MACRA and the QPP that disproportionately impact nonphysician qualified health care providers such as occupational therapists, physical therapists, and speech-language pathologists. In addition, there are logistical and operational barriers for therapists to participate in MIPS and AAPMs. Some of the current challenges facing therapy providers include:

- **MACRA Has Not Stabilized Payment Under the Medicare Physician Fee Schedule.** MACRA sought to stabilize payments by repealing the Sustainable Growth Rate formula and providing payment adjustments under the QPP. Despite that goal, these changes replaced relief from the growth rate cuts with payment cuts to the conversion factor – as a result, budget neutrality requirements limit the effectiveness of payment incentives provided under MIPS and have required annual legislative intervention to stave off untenable cuts to payment. Further, nonphysician providers, including therapists, have few options to receive payment adjustments under the QPP that would otherwise serve to offset payment cuts. In 2021, the average payment per therapy claim *was the same as it was in 2010*. Since 2021, therapy services have been cut further because of reductions to the conversion factor. An additional 15% cut to services provided by occupational therapy and physical therapists assistants was implemented in 2023. In rural and underserved areas, assistants provide 36% of all OT and PT services. This decrease in payment is simply not sustainable if we are to have a robust workforce that supports access to rehabilitation therapy services nationwide. From 2018 to 2022, applications to occupational therapy educational programs declined by 33%. At the same time, the U.S. Bureau of Labor Statistics projects the need for a 14% increase in occupational therapy practitioners over the next decade. Providers are suffering under a workforce shortage and MACRA policies are reducing resources needed for adequate therapists to meet patient access needs.

- **Inability of facility-based outpatient therapy providers to participate in bonus payment structures.** While outpatient private practice therapy services are paid under the Medicare Physician Fee Schedule, or MPFS, services provided in facility-based settings, such as hospital outpatient departments, rehabilitation agencies, and skilled nursing facilities are not considered to be a part of the MPFS. Rather, the 1997 Balanced Budget Act required that payments for facility-based outpatient therapy services be “based-on” the value of those services as set forward in the MPFS. While therapy services provided under the fee schedule are billed through an individual’s National Provider Identifier, all facility-based outpatient therapy services are billed through the facility, and not the individual therapist. This distinction is not insignificant. According to [MedPAC](#), 63% of all Medicare outpatient therapy services are provided in facility-based settings, yet facility-based outpatient therapy providers have had no way to receive payment updates or bonus payments. However, these services are subject to budget neutrality cuts and any other policy affecting therapy payments through the physician fee schedule – such as the multiple procedure payment reduction, also known as MPPR, and cuts to services provided by occupational therapy and physical therapist assistants.
- **QPP Does Not Promote Value-Based Care or Effectively Measure Quality of Care.** The QPP does not allow for adequate participation for therapists in either MIPS or AAPMs. The lack of appropriate quality metrics and a failure to include all outpatient providers of therapy services in MIPS and AAPMs have prevented the shift to value-based care. These problems are compounded by slow and ineffective mechanisms used to innovate within the QPP. This means therapists who were not fully considered in the QPP’s design still cannot meaningfully participate.
- **Barriers to Therapist Participation in MIPS.** Most therapists are not required to participate in MIPS but are encouraged to opt in to the program. However, extremely limited payment incentives serve to dissuade optional participation given that the cost of compliance outweighs even the highest historical incentives earned under the programs. Without specialty measurement sets, therapy cost measures, or otherwise comparable options available to most physicians, therapists have few reasons to participate under the program and suffer compounding pay cuts under the MPFS without any opportunity for mitigation through the QPP.
- **CEHRT is a Threshold Barrier for Therapists in MIPS and AAPMs.** Promoting interoperability through Certified Electronic Health Record Technology, or CEHRT, was part of MACRA’s original vision. AAPMs promote this by requiring CEHRT as a prerequisite for AAPM opportunities, and under MIPS providers are scored on the “promoting interoperability” measure category. CEHRT options are simply not available for therapists, as their requirements are costly, burdensome, and contain many requirements that are specific only to physicians. As a result, therapists cannot participate in AAPMs, and will receive scores of zero under MIPS in the interoperability category. Without vendors working to develop CEHRT for therapists (in part because there aren’t enough potential users to justify vendors’ expense of CEHRT development), these providers will never be able to participate meaningfully. Requirements must be relaxed or modified, otherwise therapists will continue to be assessed on an uneven playing field.
- **Barriers to Participation in AAPMs.** In addition to CEHRT as a threshold barrier to participation, the Qualifying Participant, or QP, threshold to earn incentives under the program also is not realistically achievable for therapists. Further, while there is a Partial QP designation, it does not offer any incentives to participate, and serves more to prepare clinicians who believe they would meet the QP threshold in the future. AAPMs could have therapist-specific thresholds or offer incentives for partial QPs to incentivize participation by therapists.

The challenges that MACRA has created for therapy providers are compounded by the current budget neutrality policies under the MPFS that have resulted in year-over-year cuts. Despite Congress’s annual intervention since 2020 to provide additional funding to the fee schedule to mitigate the impact of the cuts,

therapy providers still had to absorb multiple payment reductions. The challenges associated with budget neutrality threaten to re-create the decades-long problems created by the Sustainable Growth Rate; an urgently needed solution is necessary to prevent increased spending associated with temporary, year-end fixes.

## **Recommendations**

To provide greater stability under the MPFS for nonphysician providers such as rehabilitation therapists, and to help account for a decade of cuts to payments for rehabilitation therapy services, we recommend the following policies be included in any legislative package aimed at reforming the Medicare Physician Fee Schedule to ensure patient access to care and stability of providers.

### **Eliminate the Multiple Procedure Payment Reduction Policy**

The MPPR Policy, first implemented in 2011, applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B. Because of MPPR, when therapists bill more than one “always therapy” service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first are subject to a reduction in the practice expense portion of that code.

Under this policy, the therapy service with the highest practice expense value is reimbursed at 100%, and the practice expense values for all subsequent therapy services, provided by all therapy clinicians, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced. In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from Jan. 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress implemented a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR).

Our organizations have opposed the MPPR policy since its inception. It is inherently flawed, because the American Medical Association Relative Value Scale Update Committee, which assigns values to CPT codes, already ensures that any potential duplication in work or practice expense is addressed as part of the code valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes. The application of MPPR to the “always therapy” codes results in a duplicative and excessive reduction of these codes and is having a significant impact on the financial viability of therapy practices — ultimately impacting access to vital therapy services.

The percentage of payment reduction was arbitrarily decided by the 112th Congress and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that OT, PT, and SLP interventions are separate and distinct from each other. When CMS first proposed the MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that it does “[not believe it would have been appropriate for us to consider institutional patterns of care.](#)” (See page 70).

With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session. For instance, if therapeutic exercises using hand weights are provided for one unit, followed by self-care retraining in the kitchen for one unit, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own disinfection, patient positioning, and other set-up and clean-up processes before and after the procedure. Under the current policy,

despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit is reduced even though the values of the two codes do not include any duplicative cost.

MPPR also applies across therapy disciplines delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline (e.g., physical therapy) would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline (e.g., occupational therapy or speech-language pathology) delivering services on that date would have all provided service units reduced. This occurs even though the expertise, equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date, which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic.

### **Provide Flexibility in the Supervision of Assistants and Determine Challenges Facing the Therapy Workforce in Rural and Underserved Areas**

Medicare allows for general supervision of occupational therapy assistants by occupational therapists, and physical therapist assistants by physical therapists in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states is general supervision of OTAs and PTAs, making this an outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. Standardizing a general supervision requirement for private practices will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries. A bill pending introduction in the 118<sup>th</sup> Congress addresses this problem by enacting language to change the Medicare supervision requirement for OTAs and PTAs in private practice from direct to general supervision in states with licensure laws that allow for it. According to an independent report published by Dobson DaVanzo & Associates in September 2022, this change in supervision is estimated to save up to \$271 million over 10 years.

The inconsistency of supervision policies between settings jeopardizes employment opportunities for OTAs and PTAs as well as the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services. Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give private practices more flexibility in meeting the needs of beneficiaries. This small modification would better promote timely access to therapy services.

Congress should also direct the Government Accountability Office to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by OTAs and PTAs, which went into effect in 2022, has impacted access to occupational therapy and physical therapy services in rural and medically underserved areas, across all Medicare Part B settings. Beneficiaries in those areas are twice as likely to receive OT or PT services from an assistant. Rehabilitation therapy providers report that rural areas suffer significantly from the ongoing workforce shortage. A GAO report to be completed by December 2024 will provide greatly needed information and data regarding the impact of this payment differential and how it disproportionately impacts these regions.

### **Reform MACRA to Allow Broader Participation by Therapy Providers**

Within MACRA, the QPP has posed significant challenges to nonphysician providers, including PTs, OTs, and SLPs. Therapists in particular have struggled to meaningfully participate in MIPS or engage in AAPMs, in part because CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy

providers and allow them to provide effective oversight of the QPP to determine its effectiveness at measuring therapy performance and outcomes.

The value of any quality program depends on the ability of all providers to participate. To address the current shortcomings of the QPP including limited opportunities for therapists' participation in the program, Congress should authorize a stakeholder workgroup to identify barriers and develop recommendations for the Secretary of the Department of Health and Human Services on rulemaking to ensure that the QPP comprehensively measures the impact of all care received by Medicare beneficiaries.

### **Reduce the Impact of Inflation on Providers and the Patients They Serve**

Providers paid under the Medicare Physician Fee Schedule do not receive the annual inflationary update upon which virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. Providing an annual inflationary payment update to the Medicare Physician Fee Schedule's conversion factor based on the Medicare Economic Index, or MEI, will provide much-needed stability to the Medicare payment system. The MEI is a measure of inflation faced by health care providers with respect to their practice costs and general wage levels.

Health care providers, including rehabilitation therapists, continue to face increasing challenges as they seek to provide Medicare beneficiaries with access to timely and quality care. Congress has taken action to mitigate some of the recent MPFS cuts on a temporary basis, nevertheless, reimbursement continues to decline. According to an American Medical Association analysis of [Medicare Trustees data](#), when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001 to 2023. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and alternative payment and value-based care models that are unavailable to therapists, clearly demonstrates that the fee schedule is broken. Increasingly thin operating margins disproportionately affect small, independent, and rural practices, as well as those treating low-income or other historically under-resourced or marginalized patient communities – undermining efforts to improve equity in health care and social determinants of health.

An inflationary update will provide budgetary stability to clinicians – many of whom are small business owners – as they contend with a wide range of shifting economic factors such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. A more stable payment system will also help providers to invest in their practices and implement new strategies to provide high-value care.

Our organizations strongly support the Strengthening Medicare for Patients and Providers Act (H.R. 2474), legislation that would provide such an annual inflationary update to the physician fee schedule's conversion factor based on the Medicare Economic Index to help ensure patient access to the critical services our members provide. H.R. 2474 was introduced by Reps. Raul Ruiz, D-Calif., Larry Bucshon R-Ind., Ami Bera, D-Calif., and Mariannette Miller-Meeks, R-Iowa.

### **Reduce Administrative Burden for Therapy Services Provided Under Medicare Part B**

Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment in either instance. However, under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment. Congress should direct CMS to adopt a new policy that would clarify a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan

of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist called for by CMS.

Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, we are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapy providers. The time and resources spent by both therapists and physicians in procuring a timely signature when a physician order is already present adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

### **Provide Patient Choice Under Medicare**

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers if they provide services to Medicare-eligible beneficiaries. This prevents Medicare beneficiaries from exercising their right to select the health care professional of their choice, including allowing beneficiaries to privately contract with these therapists for their care regardless of whether the therapist has elected to enroll in Medicare. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program and federal law along with physicians, physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers. Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare also negatively impacts patients' clinical outcomes and can lead to increased downstream costs to the system.

It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs. Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies. Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access.

### **Enact a Permanent Medicare Policy for Therapy Services Delivered via Telehealth**

In response to the coronavirus public health emergency in 2020, Congress passed and the President signed into law legislation that authorized CMS to significantly expand Medicare's coverage of telehealth services during the public health emergency to protect the health and safety of Medicare patients. Under the authority of Section 1135 of the Social Security Act, CMS permitted virtually all medical providers, including physical therapists, occupational therapists, and speech-language pathologists, to provide services via telehealth to Medicare beneficiaries. In late 2022, Congress approved legislation that extended Medicare's telehealth flexibilities for another two years; Medical providers will be permitted to treat Medicare patients via telehealth until Dec. 31, 2024. After that date, unless Congress acts, Medicare patients may lose coverage of telehealth visits.

Continued access to telehealth services provided by physical therapists, occupational therapists, and speech-language pathologists would allow Medicare beneficiaries to maintain access to critical health care services utilizing the method of delivery in-person or telehealth of their choice. The June 2023 MedPAC Report highlighted that over 90% of Medicare beneficiaries surveyed who had at least one telehealth visit with a clinician stated that they were very or somewhat satisfied. Additionally, clinicians surveyed by MedPAC indicated that, on average, less than 10% of their services were delivered via telehealth. Finally, a report by the HHS Office of Inspector General found that less than 0.2% of Medicare telehealth claims were considered high risk. Telehealth presents a way to provide access to care for patients both in rural and urban areas who

may have trouble getting to appointments due to distance, mobility or transportation issues, or who cannot afford to take time off of work. Services delivered using telehealth also provide access to therapy in areas of our country where there simply are no therapists available. Telehealth has been demonstrated to be a service delivery mechanism that is used judiciously by health care providers in consultation with their patients who maintain high levels of satisfaction. Furthermore, initial data indicates concerns over fraud, waste, and abuse may not be as significant as initially feared.

Our organizations support the Expanded Telehealth Access Act (H.R. 3875), legislation that would add therapy providers in private practice, as well as facility-based outpatient therapy providers under Medicare Part B, as permanent authorized providers of telehealth services under Medicare. H.R. 3875 was introduced by Reps. Mikie Sherrill, D-N.J., and Diana Harshbarger, R-Tenn.

## **Conclusion**

Our organizations appreciate the opportunity to provide our recommendations to the committee that will provide long-term stability and reform to the Medicare Physician Fee Schedule.

Sincerely,

ADVION (formerly National Association for the Support of Long Term Care)  
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