NARA
The National Association of Rehabilitation Providers and Agencies

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Catherine Hayes, Executive Director
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Amy Zhou, Senior Policy Advisor
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GOP Doctors Caucus
US House of Representatives

RE: Request for Information: CMMI Models and MIPS

Dear Ms. Hayes and Ms. Zhou,

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapists (PT), occupational therapists (OT), and speech language pathologists (SLP) 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 (SNFs), assisted living facilities (ALFs), retirement communities, hospital inpatient and outpatient, and in the beneficiary's home. As a member-driven organization, NARA promotes best practice 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 of the Centers for Medicare and Medicaid Services ("CMS"); thus, we are pleased to provide the following feedback per your request of information.

Congress should prioritize legislative reforms that strengthen model design, transparency, provider participation, and the pathway from "pilot" to "program" to ensure future CMMI models deliver measurable improvements in cost and quality and can successfully scale what works from the rehabilitation provider perspective (physical therapy, occupational therapy, and speech language pathology across settings), the following reforms are most needed:

- **Clarify and modernize CMMI's statutory authority and goals**
    - Define "quality" beyond utilization by requiring functional outcomes, patient-reported outcomes, safety, and equity metrics that reflect rehabilitation's impact (mobility, ADLs, falls, return-to-work, caregiver burden), not just spending trends.

    - Require clinically valid patient stratification (risk adjustment and case-mix) so models don't penalize providers who treat complex patients and don't create incentives to avoid high-need beneficiaries.
- **Establish a predictable, provider-safe pathway to scaling**
    - Create a clear "off-ramp/on-ramp" framework: when a model demonstrates success, CMMI should have an explicit, time-limited pathway to scale with phased implementation, guardrails, and monitoring.
    - Require congressional notification plus public evidence thresholds before mandatory expansion, with defined criteria for what constitutes "real improvements" and what constitutes unacceptable access or equity impacts.
    - Support replication grants/technical assistance so smaller, rural, and safety-net rehab providers can adopt proven innovations rather than being crowded out by large systems.
- **Mandate transparency, independent evaluation, and timely data access**
    - Shorten the feedback loop by requiring CMMI to provide participating providers with near-real-time performance data, attribution lists, benchmark logic, and driver analyses so providers can make improvements timely.
    - Independent evaluation standards: legislate minimum methodological requirements (comparison groups, sensitivity analyses, access monitoring, subgroup reporting) and publish results on a predictable timeline.
    - Model documentation requirements: public release of financial methodology, risk adjustment, waiver use, and rationale for metric selection to enable informed participation and accountability.
- **Build a true multi-disciplinary approach, including rehabilitation, into model governance**
    - Stakeholder governance requirements: require CMMI to include rehabilitation clinicians and outpatient therapy operators on technical expert panels and model advisory groups when models include episodes or populations where function is a key outcome (e.g., orthopedic, neurologic, frailty, post-acute transitions).
    - Test design for care pathways: explicitly require models to address care transitions and functional recovery not only acute utilization so the model measures what it intends to improve.
- **Reduce administrative burden and align incentives across Medicare programs**
    - Standardize core operational requirements such as attribution, reporting, quality measure definitions, and audit protocols, across models to reduce implementation friction.
    - Align Medicare Advantage with tested innovations: require MA plans to recognize and operationalize proven care redesign elements (e.g., standardized documentation expectations, timely data sharing), so scaling isn't blocked by MA plans having different requirements and expectations.
    - Streamline waivers and documentation where appropriate, while maintaining program integrity especially for cross-setting coordination and telehealth-supported rehab.

- **Ensure payments support participation and sustainability, especially for rehab providers**
    - Upfront infrastructure support such as care coordination payments, HIT support, and start-up funding that is required for meaningful participation, not just retrospective shared savings that many providers never realize.
    - Guardrails against under-service: include access-to-care and functional outcome "floors," and require monitoring for stinting, delayed starts of care, and inappropriate substitution (e.g., fewer visits without comparable outcomes).
    - Promote interoperability and digital enablement through statutory requirements and funding for standardized exchange of care plans, outcomes, and referrals (particularly critical for community-based rehab).
- **Strengthen health equity and access protections as model "must-haves"**
    - Require model designs to include rural and underserved participation strategies, language access, disability-accessible measurement, and stratified reporting.
    - Add access monitoring triggers: if a model correlates with reduced therapy access, longer wait times, or less favorable functional outcomes for vulnerable groups, CMMI must modify or pause implementation.
- **Create accountability for model lifecycle management**
    - Sunset and revision requirements: mandate periodic model redesign based on evidence; prevent prolonged participation in models that do not meet performance thresholds.
    - Provider appeal and remediation processes: establish fair and transparent processes for attribution errors, data disputes, and benchmarking anomalies, especially important for smaller therapy practices.

Congress should refine CMMI's authority to emphasize functional outcomes and access, require transparent and timely feedback to participants, fund infrastructure for broad participation, align incentives across Medicare programs, and build an explicit, evidence-based scaling pathway. These reforms will better ensure CMMI models can deliver true value lower total cost of care with demonstrably better patient function, safety, and experience while enabling rehabilitation providers to participate, innovate, and scale what works.

If MIPS is reformed or replaced, rehabilitation providers including physical therapy, occupational therapy, and speech language pathology clinicians would support a quality program that is clinically credible, outcomes-focused, and operationally feasible across the care continuum. A viable successor should move away from "reporting for reporting's sake" and toward a streamlined, learning-oriented framework that improves patient function, safety, and total cost of care while reducing administrative and financial burdens.

What a New Quality Program Could Look Like:

1. A small, universal "core set" of outcomes that matter across medicine starting with a limited number of high-value measures that are applicable across therapy specialties and sites of service, such as:
    a. Functional status and goal attainment: risk-adjusted, patient-reported and clinician-assessed where appropriate
    b. Safety outcomes: falls, medication-related harm, avoidable emergency department use, hospitalizations
    c. Patient experience and access: timely care, shared decision-making, care continuity
    d. Health equity and reliability: stratified reporting; attention to social risk without penalizing providers
2. Specialty- and setting-specific measure "modules," not one-size-fits-all checklists. On top of the core set, clinicians would select a small module aligned to their scope and setting (e.g., outpatient neuro, home-based therapy, inpatient rehab, physician practices managing musculoskeletal conditions (MSK), post-surgical recovery). This preserves clinical relevance while avoiding dozens of bespoke measures.
3. Team-based accountability aligned with real care delivery. A modern program should recognize that outcomes are produced by care teams, not isolated clinicians. It should allow:
    a. Group/virtual group reporting across collaborating practices and settings
    b. Shared accountability for care transitions and longitudinal outcomes
    c. Credit for interdisciplinary plans of care, especially for MSK, frailty, neuro, and post-acute populations
4. A "data capture once, use many times" architecture. The program should be built around automatic extraction from systems already used in care:
    a. Electronic health record (EHR), claims, registries, and standardized digital patient intake tools
    b. Minimal manual chart abstraction
    c. A national approach to interoperability and measure specifications so vendors can implement a standard process applicable to each payer/program

How to Ensure it Reduces Administrative and Financial Burdens:

1. Eliminate redundant reporting and align across payers
    a. One set of definitions and submission pathways for Medicare and, ideally, aligned with Medicare Advantage and commercial payers.
    b. Retire measures that are topped out, low value, or duplicative.
    c. Replace complex scoring games with straightforward thresholds and improvement trajectories.
        - Shorten the measure list and increase measure stability
2. Require a cap on the number of measures any clinician/group can be asked to report by a payer.

   a. Keep measures stable for multi-year cycles to support workflow integration and EHR build.
3. Provide real-time feedback
   a. Quarterly (or more frequent) performance feedback using data clinicians can verify.
   b. Clear attribution rules and an accessible dispute pathway.
   c. Audit and compliance proportional to risk, with a focus on continuous improvement rather than punitive measures.
4. Simplify participation for to ensure feasibility for more providers, regardless of their size or structure
   a. Allow default participation using claims/EHR extraction with minimal additional steps.
   b. Offer technical assistance and a "safe harbor" year for onboarding.

How to Make it Applicable to All Clinician Types and Settings:

- Standardize outcomes using risk adjustment and setting-neutral definitions. Functional outcomes and safety measures must be risk-adjusted and setting-neutral, enabling fair comparisons without penalizing clinicians treating more complex patients.
- Use condition-based "episodes" only where clinically appropriate. For conditions where rehab is central (e.g., joint replacement recovery, low back pain, stroke), the program can use episode-based outcome windows. For other areas, stick to core outcomes and modules to avoid forced-fit measures.
- Permit multiple reporting pathways
  - Individual clinician, group, Advanced Payment Model (APM) entity, facility-affiliated clinicians, and multi-setting teams
  - Options for clinicians who practice across sites (clinic, home, SNF/ALF, hospital outpatient) as institutional clinicians are currently excluded.

How to Focus Meaningfully on Real Outcomes:

- Prioritize functional and patient-reported outcomes as "first-class" measures. Rehabilitation providers recommend making functional improvement and patient goal achievement central supported by standardized instruments where feasible and supplemented with clinician-reported status when necessary.
- Utilize outcomes to ensure appropriate care delivery :
  - Track access (wait times, visit initiation, drop-off rates)
  - Monitor adverse outcomes (falls, ED visits, avoidable readmissions)
  - Require balancing measures so reduced utilization is only rewarded when outcomes improve or remain strong.
- Emphasize improvement over absolute ranking
  - Year-over-year improvement
  - Achievement of clinically meaningful change
  - High performance in complex populations

This is more motivating and favorable than a system that primarily redistributes penalties.

What Rehabilitation Providers Would Ask Congress and CMS to ensure:

- A statutory requirement that any successor program is outcomes-first, includes functional outcomes where relevant, and is administratively lightweight.
- Mandated use of automated data capture and interoperability standards.
- A hard limit on measure count, plus multi-year measure stability.
- Transparent, timely performance feedback, fair attribution, and risk adjustment.

NARA and our members support CMMI models drive value by delivering demonstrable, independently validated improvements in total cost of care and quality without restricting access or g burden onto clinicians. From the therapy perspective, successful models should measure what matters most to patients: functional improvement, safety, timely access, and sustained independence. Models must be transparent in their design and evaluation, provide timely performance feedback, use appropriate risk adjustment for clinical complexity, and include practical pathways to scale innovations that work across diverse practice settings.

Rehabilitation providers also support reforming (or replacing) MIPS with an inclusive, outcomes-driven quality program applicable to all therapy clinicians in all settings. A reformed program should minimize administrative and financial burdens by relying on data captured directly through EHRs, claims, and standardized patient-reported tools reducing manual reporting and redundant requirements. It should focus on a small set of stable, clinically meaningful measures, especially functional outcomes and patient goal attainment paired with guardrails that protect access and preserve appropriate levels of service. Ultimately, both CMMI and quality program reforms should reward measurable improvements patients value, support interdisciplinary care, and enable providers of all sizes and settings to participate and succeed.

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

Respectfully submitted,

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President of the Board, National Association of Rehabilitation Providers & Agencies