UNLEASHING PROSPERITY THROUGH DEREGULATION OF THE MEDICARE PROGRAM (EXECUTIVE ORDER 14192): AMRPA RESPONSE TO CMS' APRIL 2025 REQUEST FOR INFORMATION (RFI)

Submitted on June 10, 2025

TOPIC 1: STREAMLINE REGULATORY REQUIREMENTS

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

To reduce administrative burden without compromising patient safety or program integrity, AMRPA recommends that CMS remove the requirement for IRFs to collect and submit complete IRF-PAI assessments for patients from all payers (i.e., non-Medicare). CMS does not use any of the IRF-PAI information from non-Medicare patients for payment or IRF QRP quality measures and public reporting. Currently, this information is used solely for the purposes of IRF QRP compliance and payment determinations, where failure to submit complete IRF-PAI assessments for at least 95% of patients from all payers results in a 2% payment fee-for-service (FFS) reduction in a future fiscal year. We question why CMS would impose such a drastic reduction in payment for Medicare patients based upon data collection requirements for non-Medicare patients, given that the data is not even utilized for payment or quality purposes.

AMRPA therefore strongly recommends that CMS (1) remove requirements to collect and submit complete IRF-PAI information for non-Medicare patients and (2) exclude non-Medicare patients from the IRF QRP compliance and payment determinations. Specifically, AMRPA recommends that CMS modify regulatory text at §§ 412.604(c), 412.606(a)(1), 412.606(b)(1), and 412.601(f) to remove requirements for non-Medicare patients.

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

As part of our efforts to help CMS improve and streamline the IRF-PAI, AMRPA performed an analysis of the IRF-PAI and data elements that have been added or modified over time to capture current reporting burdens. We determined that, in the 10+ years since the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) was enacted, the following changes have occurred:

- The IRF-PAI has expanded from 4 pages to 31 pages, adding nearly 350 IRF-PAI assessment data elements (348 total, 200 admission assessment and 148 discharge assessment data elements). Correspondingly, the IRF QRP has expanded and the IRF Prospective Payment System (PPS) has been modified to utilize a new set of functional data elements.

- 313 of the total 348 IRF-PAI assessment data elements (173 admission and 140 discharge data elements) are currently required to determine IRF QRP compliance. However, only 108 of these 313 data elements required to determine IRF QRP compliance are used in the calculations of IRF QRP measures.

- Of the 35 IRF-PAI assessment data elements that are not required to determine IRF QRP Compliance, 26 are used in the calculations of IRF QRP measures.

- In total, then, there are 134 IRF-PAI assessment data elements that actually used for the calculation of IRF QRP measures.

- For the IRF PPS, only 18 items (the 16 admission Section GG items and two Section H items - all added after 2014) are included in the Case Mix Group (CMG) Motor Score used for payment. These 18 items are also used for the calculation of IRF Quality measures (all other factors used for the CMGs were already in place prior to 2014).

In all, these data suggest that there are as many as 214 IRF-PAI assessment data elements that are collected as Standardized Patient Assessment Data Elements (SPADEs) following the IMPACT Act that do not apply to the IRF QRP or IRF PPS. These "unused" elements, therefore, create extensive and unnecessary administrative burden without any clear justification. We believe these elements essentially represent "reporting for the sake of reporting," and they are therefore ripe for action in this Administration's burden reduction efforts.

To help CMS address these significant disconnects between data collection and data utility, AMRPA conducted a member survey to identify those IRF-PAI assessment data elements that should be prioritized for removal, along with our rationale. The list below identifies the IRF-PAI sections/data elements that we believe should be eliminated to streamline the IRF-PAI without any resulting impacts on payment or quality measurement:

- Hearing, Vision, and Health Literacy
  - Element Location**:** These IRF-PAI data elements are located on page 5 (Admission) and page 19 (Discharge-Health Literacy) of the IRF-PAI.
- Signs and Symptoms of Delirium (from CAM©)
  - Element Location: These IRF-PAI data elements are located on page 7 (Admission) and page 20 (Discharge) of the IRF-PAI.
- High-Risk Drug Classes: Use and Indication
  - Element Location: These IRF-PAI data elements are located on page 16 (Admission) and page 27 (Discharge) of the IRF-PAI.
- Special Treatments, Procedures, and Programs
  - Element Location: These IRF-PAI data elements are located on pages 16-17 (Admission) and page 28 (Discharge) of the IRF-PAI.
- Therapy Information
  - Element Location: These IRF-PAI data elements are located on page 2 of the IRF-PAI. This section requires the collection of 24 data elements relating to the various therapy types and number of minutes of each therapy type for Week 1 and Week 2.

- Transportation
    - Element Location: These IRF-PAI data elements are located on page 4 (Admission) and page 18 (Discharge) of the IRF-PAI.
- Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc.©) and Social Isolation
    - Element Location: These IRF-PAI data elements are located on page 8 (Admission) and page 21 (Discharge) of the IRF-PAI.
- Pain Effect/Interference
    - Element Location: These IRF-PAI data elements are located on pages 13-14 (Admission) and page 25 (Discharge) of the IRF-PAI.

As CMS considers these removals, AMRPA also asks that CMS consider removing the Brief Interview for Mental Status (BIMS) and Staff Assessment for Mental Status data elements. In its assessment, however, AMRPA asks the agency to identify alternative ways of risk-adjusting discharge functional score expectations for cognitive function/status that are based upon data elements or other assessments that are more reliable and valid for identifying cognitive deficits or impairment.

Additional information - including rationale for removing each of the IRF-PAI data elements identified above – is further detailed in the AMRPA fiscal year (FY) 2026 IRF Proposed Rule Comment Letter.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) mandates the submission of timely and accurate data to comply with federal quality reporting requirements. The QRP includes a 2% penalty on all Medicare payments made to an IRF in the following fiscal year after noncompliance with the reporting requirement is identified.

As background, the purpose of the 2% penalty was originally designed to incentivize providers to comply with the QRP program. At this point, however, the vast majority of providers exercise good faith in complying with the IRF QRP. Despite these high compliance rates, CMS continues to impose severe financial penalties for minor or technical errors in a byzantine reporting system. Of primary concern is the current reporting infrastructure for the Center for Disease Control's National Healthcare Safety Network (NHSN) portal, as this system does not provide real-time, formal confirmation that data submissions have been successfully received and accepted. Without real-time confirmation or other real-time reporting opportunities, some providers have resorted to using screen captures as a means to justify compliance with data submission requirements. AMRPA also notes that CDC NHSN measure information may be provided in reporting available in the CMS Internet Quality Improvement & Evaluation System (iQIES); however, these reports do not provide real-time information on the CDC NHSN measures and have provided incomplete results when assessing compliance with IRF QRP requirements.

As a result, penalties are widely regarded by providers at this point as a punitive and unjustified recoupment of Medicare payments that enriches the Medicare program at the expense of providers who serve patients and believe they are in full compliance.

Based on our members experience, we respectfully urge CMS to require implementation of a **real-time, system-generated proof of submission notification** for providers submitting IRF QRP data. Specifically, we request that:

- The notification is generated **at the time data is entered into the NHSN portal**, including key elements such as the provider identifiers for the specific reporting entity, submission date/time, and type of data submitted.
- Any notification of a submission deficiency or error is issued **sufficiently before the submission deadline** to allow providers to make timely corrections, including time to access assistance from the available helpdesks and other resources to identify the specific deficiency and means of correcting it.
- CDC/CMS improve the clarity and completeness of submission status reports, ensuring they include all necessary information and are easily interpretable by providers.

Essentially, the current system sets up providers to fail. Without timely, definitive confirmation or actionable error notices *as the data is actually submitted in real time* - much like the vast majority of commercial websites where consumers purchase goods - providers risk unknowingly failing to meet submission requirements. This risk can persist across multiple reporting cycles, compounding the harm. With formal confirmation, IRFs can more quickly identify submission errors or failures and take corrective action within submission timelines. This is particularly important since errors that are not identified prior to the start of the next reporting period can persist until notification from CMS in June or July of the following year. This creates a situation where the same error - that could have been rectified if identified earlier - can cause a finding of deficiency in two different fiscal years, subjecting the provider to the 2% penalty for two years in a row. These penalties can reach hundreds of thousands of dollars, if not millions, depending on the size of the IRF and the number of their Medicare payments. Considering that these penalties are often levied in instances such as failure to check a box or make an incorrect date entry, AMRPA believes that the penalty is significantly disproportionate to the nature and magnitude of the reporting error and requires multi-faceted reform.

A standardized, automated confirmation would ease the administrative burden, reduce uncertainty, and align IRF QRP practices with other CMS quality programs that already issue submission acknowledgements. Specifically, it would relieve the burden on providers of generating their own internal validation procedures that are not standardized and are subject to staff or technological error. Proof of submission documentation would support fairness in enforcement, enabling providers to demonstrate good faith efforts to comply and better defend against inadvertent deficiencies. In too many cases providers receive notifications of deficiency and are unable to discern what the actual error may have been, requiring appeal of the finding in order to receive a more detailed description from CMS of the nature of the error(s) alleged.

CMS entertains a reconsideration process for IRFs to attempt to have their 2% penalty reversed. However, in the event of a denial of reconsideration, the only remaining option is for IRFs to file

an appeal with the Provider Reimbursement Review Board (PRRB). These appeals typically require legal counsel to draft and file a complaint and accompanying briefs and argue the case before the PRRB. Since the PRRB lacks equitable jurisdiction, it is not empowered to relieve the financial penalty even if it finds the reporting error was minor, technical, unintended, or immaterial. The penalty is almost invariably upheld.

In sum, the absence of a clear, timely, and complete confirmation mechanism creates unnecessary compliance risks for IRFs and undermines the integrity of the IRF QRP. Implementing a real-time proof of submission notification system—especially at the point of data entry into the NHSN portal—would significantly enhance transparency, improve fairness, and support CMS' goals of data quality and provider accountability.

TOPIC 2: OPPORTUNITIES TO REDUCE BURDEN OF REPORTING AND DOCUMENTATION

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

To simplify Medicare reporting and documentation requirements without affecting program integrity or meaningful quality reporting, AMRPA recommends that CMS identify measures for QRP removal based on CMS' established criteria (§ 412.634(b)(2)). Specifically, we note that one criterion identifies circumstances where "measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made." CMS has also defined a "topped-out" measure as one whose median performance score is 95% or higher, and whose performance is "so high and unvarying that meaningful distinctions and improvement in performance can no longer be made."

Based on our consideration of the current QRP and relevant criteria, AMRPA has identified four IRF QRP measures that should be removed based on these standards. Our recommendations follow:

1. We urge CMS to remove the measure tracking the "percentage of IRF patients who experience one or more falls with major injury during their IRF stay." In the most recently published refresh of quality measure data on Care Compare (March 2025), the national observed rate for IRFs on this measure is 0.2%, with 51.5% of IRFs (623 out of 1226) reporting a measure value of 0% and another 39% of IRFs (477 out of 1226) reporting a measure value less than 1%. Based upon these values, this measure provides very limited opportunity to improve performance or meaningfully distinguish performance between IRFs. Removal of this measure would not signal a lack of importance of measuring the incidence of falls of IRF patients, but the measure no longer meaningfully identifies opportunities for improvement in this area.

2. We urge CMS to remove the measure tracking "percentage of patients with pressure ulcers/pressure injuries that are new or worsened." In the most recently published refresh of quality measure data on Care Compare (March 2025), the national observed rate for IRFs on this measure is 1.0%, with 14.1% of IRFs (173 out of 1226) reporting a measure value of 0%, and another 39.9% of IRFs (489 out of 1226) reporting a measure value less than or equal to the national observed rate of 1%. Based upon these values, this measure provides limited opportunity to improve performance or meaningfully distinguish performance between IRFs, despite the importance of preventing pressure ulcers in IRF patients.

3. We urge CMS to remove the measure tracking "percentage of patients whose medications were reviewed and who received follow-up care when medication issues were identified." In the most recently published refresh of quality measure data on Care Compare (March 2025), the national observed rate for IRFs on this measure is 98.1%, with 21.3% of IRFs (261 out of 1226) reporting a measure value of 100%, and another 47.1% of IRFs (578 out of 1226) reporting a measure value at or above the national observed rate of 98.1%.

Based upon these values, this measure provides a limited opportunity to improve performance or meaningfully distinguish performance between IRFs.

4. Finally, we urge CMS to remove the measure tracking the "percentage of patients where the IRF reviewed and provided a medication list to the patient, family, and/or caregiver at final discharge." In the most recently published refresh of quality measure data on Care Compare (March 2025), the national observed rate for IRFs on this measure is 97.7%, with 31.9% of IRFs (391 out of 1226) reporting a measure value of 100%, and another 23.7% of IRFs (290 out of 1226) reporting a measure value at or above the national observed rate of 97.7%. Based upon these values, this measure provides very limited opportunity to improve performance or meaningfully distinguish performance between IRFs.

Furthermore, AMRPA has identified three other IRF QRP measures that we believe meet additional criteria outlined in the regulations and should therefore be removed from the QRP.

1. We recommend that CMS remove the catheter-associated urinary tract infections (CAUTI) measure based on two criteria. AMRPA finds that this measure meets the required showing that performance among IRFs is sufficiently high and unvarying that meaningful distinctions in improvements in performance can no longer be made. The publicly reported values are identified as "Not Available" for over 60% of IRFs (757 out of 1226), due to circumstances where there are zero reported instances of patients with an infection, or the predicted number of infections is less than one patient. Of those with a reported value, 129 IRFs have a Standardized Infection Rate (SIR) of 0. Based on this data, we do not believe this measure provides meaningful distinctions between IRFs, and relatedly, offers no opportunity to improve performance for the majority of IRFs.

   Furthermore, we believe that the measure does not align with current clinical guidelines or practice and can be removed from the QRP on this ground. As documented by prominent spinal cord injury physicians and trade associations, the CAUTI measure may not follow clinical guidelines for care for Spinal Cord Injury (SCI) patients with a neurogenic bladder condition, requiring ongoing bladder management methods like catheterization. These specialists have raised concerns that the CAUTI guidelines, as they were initially structured, might lead to the premature removal of catheters in SCI patients in order for providers to "meet the measure" - which can have severe consequences for these patients. Some hospital systems have implemented protocols to remove catheters early to reduce CAUTI rates, which can be appropriate in many situations, but can also be dangerous for patients with SCI. Based upon these circumstances, AMRPA believes that this measure does not align with current clinical guidelines and should therefore be removed.

   Finally, we believe the costs associated with a measure outweigh the benefit of its continued use in the program. Reporting for this measure requires both patient-level reporting as well as monthly provider-level reporting in the CDC National Healthcare Safety Network (NHSN) system. This often requires an Infection Control specialist as well as other clinicians within an IRF to complete this reporting accurately. IRFs are also

required to submit monthly data when there are no instances of catheter utilization that could contribute to a urinary tract infection (UTI). The costs associated with the reporting of this information produce little to no value to the Medicare program or its beneficiaries and therefore should be removed from the IRF QRP based on this criterion.

2. We recommend CMS remove the Clostridium difficile Infection (CDI) measure. Similar to the CAUTI measure, AMRPA believes that this measure should be removed based on numerous criteria. First, we believe this measure satisfies the showing that performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made. In the most recently published refresh of quality measure data on Care Compare (March 2025), the national Standardized Infection Rate (SIR) for IRFs on this measure is 0.375, meaning that the actual number of infections is much less than the predicted number of infections. The publicly reported values are identified as "Not Available" for nearly 21% of IRFs (255 out of 1226), due to circumstances where there are zero reported instances of patients with an infection, or the predicted number of infections is less than 1 patient. Of those with a reported value, 374 IRFs have a Standardized Infection Rate (SIR) of 0, and another 519 IRFs have an SIR of less than one. This measure, therefore, does not provide meaningful distinctions between IRFs and offers limited opportunity to improve performance for the majority of IRFs.

   Similar to CAUTI, we also believe this measure satisfies the showing that the costs associated with the measure outweigh the benefit of its continued use. The reporting for this measure requires both patient-level reporting as well as monthly provider-level reporting in the CDC NHSN system. This often requires an Infection Control specialist as well as other clinicians within an IRF setting to complete. The costs associated with the reporting of this information therefore produce little to no value to the Medicare program or its beneficiaries and should be removed from the IRF QRP.

3. Finally, we urge CMS to remove the NHSN Influenza Vaccination among Healthcare Personnel measure based on numerous grounds. First, the measure meets the required showing that performance or improvement on a measure does not result in better patient outcomes. There is no evidence to suggest that performance on this measure is correlated to any other outcomes for IRFs. In other words, higher Healthcare Personnel vaccination rates are not associated with higher discharge functional scores or discharge to community rates, nor are they associated with lower within-stay readmission rates.

   Further, the costs associated with a measure outweigh the benefit of its continued use in the program. Similar to the HCP COVID-19 Vaccination measure (a measure proposed to be removed from the IRF QRP through the FY 2026 IRF rulemaking), IRFs must report data on flu vaccination coverage among HCP for the flu season (October-March). This requires IRFs to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers and other contract personnel and enter information into the CDC NHSN system. Since the measure performance is not aligned with other outcomes, the costs associated with tracking and reporting this information provide no benefit to the Medicare program or beneficiaries.

2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

We urge CMS to review AMRPA's response to the FY 2026 IRF Prospective Payment System and Quality Reporting Program proposed rule for an extensive overview of IRF-Patient Assessment Instrument (IRF-PAI)-focused recommendations.

2C. Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number. (Note: The OMB Control Number consists of two groups of four digits joined by a hyphen and it generally appears on the top right of the first page of a Medicare form and the CMS form number generally appears on the bottom left of the page of a Medicare form.)

AMRPA believes the Admission Schedule requirements in regulatory text at §§ 412.610 are outdated, overly complex, redundant, and inconsistent with current practice. The deadlines for completion and encoding of the admission and discharge assessments were established when the IRF-PAI was only 3-4 pages, and the assessment information was solely used for payment purposes. Since the IMPACT Act of 2014, the IRF-PAI has expanded to 30 pages including information for both payment and quality reporting purposes. While adding 26-27 pages and nearly 350 additional data elements to the IRF-PAI, the deadlines for completion and encoding have not been updated to accommodate the immense burden placed upon IRFs to perform the various assessments within the IRF-PAI, document the assessment information in the electronic medical record, translate the medical record documentation into the codes to be entered onto the electronic IRF-PAI forms, and finally electronically transmit this information into the CMS Internet Quality Improvement & Evaluation System (iQIES) platform.

AMRPA believes that these requirements are also overly complex, as there is no guidance or additional information to indicate what constitutes completion of the assessments or what would differentiate completion from encoding. For instance, IRF providers often question whether it is sufficient for the medical record to contain documentation indicating completion of the various assessments contained within the IRF-PAI or does "completion" require that the IRF-PAI form itself be filled out. And since the IRF-PAI form is now electronic, it is unclear whether entering values into each of the IRF-PAI fields constitute "completion" or "encoding." AMRPA believes these requirements derive from a time when paper was primarily used for recordation and claims submission and believes that these regulations should be waived, modified, or simplified to represent the current state of electronic recordkeeping and transfer of data.

Furthermore, CMS removed requirements for a late payment penalty, making these deadlines unnecessary with respect to Medicare payment for IRF services. Therefore, currently, CMS has regulations in place that set deadlines that have no impact on payment, other than to be overly punitive when these regulations are strictly interpreted as part of audits or reviews of IRF services.

AMRPA also believes that these deadlines are redundant and inconsistent with deadlines for IRF-PAI data submission under the IRF QRP. Section 1886(j)(7)(C) of the Social Security Act (the Act) provides HHS with discretion to prescribe the form and manner and the timeframes for IRFs to submit data as specified for reporting for the IRF QRP. In the FY 2016 IRF PPS final rule (80 FR 47122), CMS finalized that IRFs will have approximately 4.5 months (135 days) after each quarterly data collection period to complete their data submissions and make corrections to such data where necessary. Since IRFs have 4.5 months to complete IRF-PAI data submissions to meet quality reporting standards, CMS' regulatory text that sets deadlines for the completion and encoding of IRF-PAI assessments (that are not used for payment) and occur well in advance of established deadlines for quality reporting should be removed.

For these reasons, AMRPA recommends that CMS remove the completion deadlines in regulatory text at §§ 412.610(c)(1)(i)(C) for the admission assessment and §§ 412.610(c)(2)(i)(B) for the discharge assessment. AMRPA also recommends that CMS remove the encoding requirement at §§ 412.610(d). Finally, AMRPA recommends modifying the transmission requirement at §§ 412.614(c) to reference the IRF QRP data submission deadline as the requirement.

TOPIC 3: IDENTIFICATION OF DUPLICATIVE REQUIREMENTS

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

AMRPA strongly supports this Administration's work to improve auditing within the Medicare program without creating any program integrity risks. As part of this effort, AMRPA believes there are several important reforms that could be implemented in IRF-specific audits to make the program more effective for both providers and CMS.

First, there are several aspects of the administrative appeals process that could be better coordinated between the Medicare Administrative Contractors (MACs), the Qualified Independent Contractor QIC), the Office of Medicare Hearings and Appeals (OMHA), the Medicare Appeals Council of the Departmental Appeals Board (DAB), and the similar appeals process applicable to IRFs under the Medicare Advantage program. The denials rendered across these entities stem from alleged noncompliance with both medical necessity and documentation requirements, as well as claims of "down-coding" of functional status values that have the potential to negatively impact IRF reimbursement. AMRPA has the following concerns and related recommendations with the current auditing landscape:

- First, the MACs and the Administrative Law Judges (ALJs) should be consistent in their review of IRF claims. The MACs are bound by both the IRF coverage and documentation regulations at 42 CFR 622 and the Medicare Benefit Policy Manual (MBPM)—which is far more detailed in its documentation requirements—while the ALJ's are only bound by the regulations. ALJ's give deference to the MBPM but are not bound by it. This creates denials of payment for IRF claims at the MAC level of review that are eventually overturned in favor of providers when a *de novo* hearing is held before an ALJ. Aligning these reviews between MACs and ALJs would reduce the burden on providers of appealing IRF denials that are initially found out of compliance with the MBPM but, eventually, found by ALJs to be compliant with the regulations alone.
- The QIC is supposed to be a level of review whereby medically trained personnel are supposed to conduct, as the name states, an independent review of a denied claim. However, long-standing IRF experience strongly suggests that IRFs rarely obtain reversal of claim denials based on alleged noncompliance with medical necessity or documentation requirements at the QIC. Rather, this level of review often serves as a "rubber stamp" of the MAC decision and simply delays the opportunity for a provider to be heard before an impartial ALJ. CMS should closely examine the cost-benefit of the current QIC level of review and seek ways to improve it to make it more efficient, effective, and functional as a true arbiter of disputes.
- The Medicare Appeals Council within the DAB is the last level of administrative review before an IRF (or any Medicare provider) can appeal a claim denial to a federal court. But there is a major backlog of cases pending at the Medicare Appeals

Council that often delays decisions in these cases by several years. Some of our IRF members have recently reported that Medicare Advantage plans are routinely appealing ALJ decisions decided in favor of the IRF patient/provider, delaying a final determination in these cases by years, regardless of the merits of the case. In the case of MA, these denials usually stem from prior authorization requests where IRF care is not approved and the prior authorization denial is then appealed. In most instances, the patient waits for years to obtain approval for the IRF care to which they are entitled under the program. Of course, years of delay of IRF care in many instances obviates the need for intensive, coordinated, interdisciplinary IRF care, thereby rewarding the MA plan for appealing the claim to the DAB, regardless of the merits of the care. These delays are tantamount to denials of care and must be addressed and prevented. CMS should examine this recent phenomenon and seek to identify ways to streamline these decisions or penalize MA plans that employ this tactic.

- Finally, CMS should also work with the Department of Health and Human Services to resolve the enormous backlog at the Medicare Appeals Council.

In addition to the time spent on the audits themselves, hospitals spend countless hours appealing denials, which are overturned at a very high rate. AMRPA supports reforms to improve audit practices, reduce provider burdens, and produce audit results that are more educational and instructive for both providers and the Medicare program. We therefore urge CMS to consider establishing a standing Medical Rehabilitation Advisory Board to ensure that Medicare medical necessity standards and enforcement reflects the real-world practice of rehabilitation medicine. This Advisory Board could advise CMS and its audit contractors on ways to accurately review medical necessity determinations as applied to IRF, given the complexity of both the IRF compliance criteria and IRF patient mix.

Lastly, to advance CMS' goals of improving provider education, CMS should require auditors to make their instructions and guidelines available for public feedback and discussion. Doing so would help make audits more educational and less punitive, and may potentially result in fewer appeals that are ultimately overturned. Relatedly, in the case of denials, CMS auditors should be required to explain how and why specific facts led to the conclusion that the patient did not meet the coverage criteria. More detailed denials would also help educate providers and reduce the occurrence of similar errors in future audits.

3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Currently, of the 17 measures included in the IRF QRP, 9 measures are identified as "not endorsed", meaning that they have not received formal endorsement for use by a consensus-based entity (CBE). The 9 IRF QRP measures that are not currently endorsed are:

1. IRF QRP Measure #1: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) [CMIT Measure ID #00520 (not endorsed)]
2. IRF QRP Measure #4: Drug Regimen Review Conducted with Follow-Up for Identified Issues–PAC IRF QRP [CMIT Measure ID #00225 (not endorsed)]

3. IRF QRP Measure #5: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [CMIT Measure ID #00121 (not endorsed)]
4. IRF QRP Measure #6: Transfer of Health (TOH) Information to the Provider–Post-Acute Care (PAC) [CMIT Measure ID #00728 (not endorsed)]
5. IRF QRP Measure #7: Transfer of Health (TOH) Information to the Patient–Post-Acute Care (PAC) [CMIT Measure ID #00727 (not endorsed)]
6. IRF QRP Measure #9: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date [CMIT Measure ID #01699 (not endorsed)]
7. IRF QRP Measure #13: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) [CMIT Measure ID #00180 (not endorsed)]
8. IRF QRP Measures #16: Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP [CMIT Measure ID #00575 (not endorsed)]
9. IRF QRP Measure #17: Potentially Preventable Within Stay Readmission Measure [CMIT Measure ID #00576 (not endorsed)]

These 9 measures require IRFs to expand a significant amount of resources to collect and report data, yet they have not gone through a process that ensures measures are evidence-based, scientifically sound, and both safe and effective for use. Since these measures have not gone through a review for endorsement, these measures have not been evaluated for meeting endorsement standards for Importance, Feasibility, Scientific Acceptability, Use and Usability, and optionally, Equity. This means that measures have been implemented by CMS for use as part of the IRF QRP even though these measures may not have evidence that:

- the measure is important for making significant gains in health care quality or cost;
- measure specifications require data that are readily available or could be captured without undue burden and can be implemented for performance measurement;
- the measure produces consistent (reliable) and credible (valid) results about the quality of care when implemented;
- potential audiences (e.g., consumers, purchasers, providers, and policymakers) could use measure results for both accountability and performance improvement to achieve the goal of high-quality, efficient health care for individuals or populations.

CMS has implemented these measures without receiving endorsement through a liberal interpretation of an exemption provided in the IMPACT Act of 2014 and stated in Section 1899B, subsection (e) (2) of the Act:

(2) Consensus-based entity.—

(A) In general.— Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1890(a).

(B) Exception.— In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

AMRPA believes that the Secretary has the ability to determine that each of the measures that are not endorsed fulfill "a specified area or medical topic". While AMRPA believes that this exception makes sense in the context of unanticipated circumstances (such as public health emergencies where endorsed measures may not have existed previously), CMS has employed this exception liberally to meet IMPACT Act-related implementation deadlines.

AMRPA therefore recommends that, with limited exception, every IRF QRP measure go through the CBE endorsement process to ensure that measures are evidence-based, scientifically sound, and both safe and effective for use. We also recommend that CMS discontinue the use and public display of the nine measures that are not endorsed until such a time as these measures are endorsed or other endorsed measures are identified and made available.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

AMRPA offers the following substantive two recommendations for CMS' consideration, which would meaningfully and effectively reduce burden for IRF providers in the Medicare program without any adverse impact on quality of care or program integrity.

1. **CMS Should Terminate the RCD**

The IRF "Review Choice Demonstration" has now been in effect for nearly two full calendar years. This program – commenced under the Biden Administration – subjects all IRFs in select states to a pre-payment or post-payment review of every fee-for-service (FFS) admission. Since the program was first proposed, AMRPA has raised concerns about the massive costs and administrative burdens placed on IRFs on account of an oversight program of this magnitude, and members have confirmed the high costs of program participation over the last two years. The program is currently operating in Alabama and Pennsylvania, with implementation pending in Texas, California, and other states.

While AMRPA has been disappointed in how infrequently CMS has posted status reports on this program, the available data show very high affirmation rates from hospitals participating in the demonstration. CMS' latest report (issued in January 2025) found that 91% of IRF admissions in the program have been affirmed as of the last reported quarter. More recent AMRPA member feedback indicates that this rate is even higher at this point in time, with most providers reporting affirmation rates above 97%.

Based on this data from both CMS and the IRF community, AMRPA firmly believes that the IRF RCD is a program that has failed to identify <u>any</u> fraud or widespread noncompliance concerns in the Medicare IRF sector. As such, the program has thus become costly, unnecessary, and purely burdensome to <u>both the government and the IRF field</u>.

Upon AMRPA's analysis, the small minority of claims that have not been affirmed in the RCD are either due to technical documentation matters or, more frequently, legitimate debates over clinical judgment and the details of patients' conditions, progress, and medical complexities. We believe that the Medicare program has a variety of more appropriate and streamlined tools to clarify the agency's interpretation of clinical coverage and documentation requirements in the IRF benefit other than the burdensome and costly RCD.

As CMS examines ways to reduce provider burdens and eliminate costs (to both the government and stakeholders) related to overreaching or unnecessary oversight programs, we believe the termination of the RCD fits squarely within these goals. We ask for CMS to take this type of action before the program commences in Texas, given that the high number of IRFs in that state will result in even more time and resources being unnecessarily diverted to this program. Relatedly, we request that CMS release more robust data on IRFs' compliance record under this program to inform current and future oversight programs and ensure that oversight entities focus on those sectors with actual and credible evidence of fraud or widespread compliance issues.

2. CMS Should Make TEAM Voluntary Across Participants & Selected Conditions

AMRPA also encourages CMS to examine the pending Transforming Episode Accountability Model (TEAM) as it identifies ways to alleviate burdens for short-term acute care hospitals, IRFs, and other members of the post-acute care spectrum. As background, TEAM is a pending Center for Medicare and Medicaid Innovation (CMMI) model developed under the Biden Administration, which will require selected acute care hospitals to participate in a five-year mandatory episodic payment model for certain surgical procedures starting in calendar year (CY) 2026. The surgical procedures included in the model are lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure, and other conditions may be added in the future. CMS will provide participants with a target price that is intended to represent most Medicare spending during an episode of care. As currently structured, all IPPS hospitals in certain core-based statistical areas (CBSAs) will generally be required to participate in TEAM. The model provides limited consideration for hospitals' size or ability to oversee an episode-based payment model with the potential to span multiple care settings and service lines. While inpatient rehabilitation hospitals and units will not qualify as "initiators," the current model structure stands to have a significant and immediate impact on post-acute care utilization and care delivery – particularly for patients in need of inpatient rehabilitation.

Based on AMRPA members' experiences with other similar models, we believe it is critical that the model first be tested among those hospitals with the requisite experience, competencies, and strong post-acute care referral partners to ensure patients receive high-quality and appropriate levels of care. These hospitals' experiences will help CMS and providers determine the appropriate target price methodology and other key model metrics such that refinements can be made prior to the broader implementation. AMRPA reiterates our longstanding support for this type of voluntary testing as a precursor to expansion and mandatory participation, as our members believe that this is among the most critical patient safeguards in any model impacting Medicare payment and care delivery.

In addition to launching the model on a voluntary-only basis, AMRPA urges CMS to further consider giving participants the ability to select which of the five proposed conditions they would like to voluntarily test. This would allow providers to focus on those episodes for which they are particularly well-equipped to coordinate the patient's care throughout their recovery trajectory and undertake the requisite financial risk. For example, hospitals that have relatively low volume for one of the conditions currently included on the list could face significant variability in performance and large losses due to only a handful of patients – an issue that was reported during the Comprehensive Care for Joint Replacement (CJR) model as well. AMRPA therefore recommends that CMS commence the demonstration with fewer covered conditions to reduce the burden and potential care disruptions within TEAM. We also urge CMS to particularly reconsider the mandatory inclusion of spinal fusion and coronary artery bypass grafting, as the target prices for these procedures are more likely to be eroded by the underlying procedure costs and therefore risk limiting the patients' ability to receive medically necessary post-discharge items and services.