SUBMITTED ELECTRONICALLY

William N. Parham, III
Director
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard, Mailstop: C4-26-05
Baltimore, MD 21244
Attn: OMB Control Number: 0938–1420

Re: Agency Information Collection Activities: Proposed Collection; Comment Request; Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services; OMB Control Number: 0938–1420; FR Doc. 2025-11900 (June 27, 2025)

Dear Mr. Parham,

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and the more than 800 inpatient rehabilitation hospitals and units we represent, we thank you for this opportunity to comment on CMS' ongoing information collection related to the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD). Given that this feedback opportunity is tied to CMS' requirements under the Paperwork Reduction Act (PRA), our comments are primarily focused on our procedural concerns related to the RCD's operations at this stage. As detailed below, we believe that CMS did not take the requisite actions needed to extend the significant information collection required by the IRF RCD, while also failing to perform a meaningful assessment of the RCD's burden and ongoing justification at this stage of the program. We believe these deficiencies raise serious questions about the RCD's operation and may warrant its termination on technical grounds.

As we note in the second section of our comments, however, we believe that CMS should sunset the RCD for reasons wholly separate from these PRA procedural concerns. While the stated goals of the program are the "identification … of potential Medicare fraud" and "improve[d] compliance with Medicare program requirements,"[1] the overall results from nearly two full years fully refute the premise of the program. The most recently-posted data from CMS and Novitas shows a very high compliance rate for both Alabama and Pennsylvania-based IRFs, and the more concurrent reports from AMRPA members indicate that many IRFs are experiencing near-perfect records in their most recent cycle.

Despite these strong compliance rates, IRFs in the RCD have faced numerous operational issues in the program, including serious lags in the performance data posted by CMS and inconsistent contractor reviews. For example, while IRFs receive nearly "real time" data about their individual program performance, CMS' most recent publicly posted data is from September

[1] *See:* CMS' Review Choice Demonstration for Inpatient Rehabilitation Facility Services Frequently Asked Questions, Pg. 2, Updated June 18, 2025 (available here: https://www.cms.gov/files/document/irf-rcd-faqs.pdf)

2024. This lack of transparency and timely reporting make it exceedingly difficult for policymakers and oversight entities to assess whether the demonstration is meeting its intended goals. As a separate but substantive issue, IRFs have also been hampered by inconsistent contractor reviews and ongoing policy "clarifications" throughout the demonstration. AMRPA members report that these updates require significant procedural changes and staff education, though these burdens are completely omitted in CMS' program justification in its most recent PRA notice.

In sum, considering the high affirmation rates and complete lack of identified fraud, as well as various operational concerns, we believe CMS should immediately work towards winding down the program altogether. Whether it be through the PRA process or as a substantive agency announcement, we encourage prompt attention to this request given the significant burden the RCD's information collection continues to impose on AMRPA members.

We appreciate your consideration of our full comments, and we stand ready to answer questions or provide technical assistance as CMS assesses the ongoing operation of the IRF RCD.

I. The RCD Should be Terminated Based on CMS' Failure to Comply with the Requirements of the Paperwork Reduction Act

In December 2020, the IRF RCD was announced through a PRA notice, which required CMS to get Office of Management and Budget (OMB) approval before initiating an information collection. Such approval requires: (1) a 60-day notice in the Federal Register, allowing for public input on the information collection request;[2] and (2) a 30-day notice by the OMB Director.[3] Other procedural requirements apply depending on whether the agency is "adopting" or "revising" a collection of information versus "extending" an existing collection of information.

Based on our review of PRA rules, we are concerned that CMS has not been compliant in seeking continued approval of the RCD from OMB. We note that CMS' initial notice was characterized as an "extension,"[4] but then later changed to a "reinstatement."[5] In our review, however, "reinstatement" is not a term used by the PRA or its implementing regulations. AMRPA and other stakeholders believe that this was potentially an attempt to account for the fact that OMB's current approval for the RCD information collection expired on March 31, 2025, thereby preventing CMS from seeking an "extension."[6] While "reinstatement" is

[2] 44 U.S.C. § 3506(c)(2)(A).
[3] 44 U.S.C. § 3507(b).
[4] Agency Information Collection Activities: Proposed Collection; Comment Request, 89 Fed. Reg. 102149 (Dec. 17, 2024).
[5] Agency Information Collection Activities: Submission for OMB Review; Comment Request; Correction, 90 Fed. Reg. 29871 (July 7, 2025).
[6] Information Collection Search Results, Office of Info. and Regul. Affs., Office of Mgmt. and Budget, https://www.reginfo.gov/public/Forward?SearchTarget=PRA&textfield=10765&Image61.x=0&Image61.y=0.

referenced in non-binding policy guidance,[7] we are concerned with CMS and OMB's use of a term not supported by statute or regulation – raising serious questions about the RCD's ongoing operation after March 31, 2025.

Furthermore, if CMS's requested collection of information is characterized as a new or revised request, AMRPA believes that the agency did not properly comply with the requirements for new or revised collection requests available at 44 U.S.C. § 3507(a), including evaluating public comments.[8] Even if the notice is characterized as an "extension," we believe CMS did not adequately comply with the requirements of extensions available at 44 U.S.C. § 3507(h) to conduct a review under 44 U.S.C. § 3506(c) or to provide "an explanation of how the agency has used the information that it has collected."[9] Critically, both of these types of requests require meaningful review of public comment and ongoing evaluation of the necessity of and burdens presented by the information collection. However, with the RCD, CMS' 60-day Federal Register notice was copied almost verbatim from CMS's 60-day 2020 Federal Register notice.[10] By largely republishing its 2020 notice despite the significant developments surrounding the IRF RCD in the intervening years (particularly the field's compliance rates), AMRPA believes that CMS did not fulfill its obligation to assess and provide detail on "the *continued* need for" the demonstration.

To summarize, the PRA requires agencies to review their information collections at certain times to ensure that they remain necessary, that they reduce burden to the extent practicable, and that they are not duplicative. CMS's actions raise serious questions about whether the agency met the relevant timing and assessment-focused requirements. At a minimum, CMS should restart its collection of information notice and comment process to comply with PRA. However, when these procedural deficiencies are considered along with AMRPA's substantive concerns with the demonstration's ongoing operation (detailed in Section II), we believe CMS should instead be compelled to sunset the program in a timely way.

II. The RCD Should be Terminated Based on IRFs' Strong Compliance Rates & Ongoing Programmatic Operational Issues

Since its implementation, the IRF RCD has impacted thousands of Medicare claims for admission to IRFs in Alabama and Pennsylvania. With nearly two years and a substantive dataset available to review IRF performance, AMRPA and our members firmly believe that the IRF RCD has failed to identify any fraud or widespread non-compliance in the Medicare IRF benefit, and has thus become extraneous, unnecessary, and purely burdensome. While CMS completely omitted performance data when seeking approval to continue collecting information through the

[7] *See* Paperwork Reduction Act (PRA) Guide, U.S. Off. Of Pers. Mgmt., (April 2011), https://www.opm.gov/about-us/open-government/digital-government-strategy/fitara/paperwork-reduction-act-guide.pdf.
[8] 44 U.S.C. § 3507(a).
[9] 44 U.S.C. § 3507(h).
[10] *Compare* Agency Information Collection Activities: Proposed Collection; Comment Request, 85 Fed. Reg. 81208 (Dec. 12, 2020) *with* Agency Information Collection Activities: Proposed Collection; Comment Request, 89 Fed. Reg. 102149 (Dec. 17, 2024).

RCD, AMRPA urges OMB and other policymakers to strongly consider these rates when determining whether the information collection request – and program as a whole – should be extended.

If the OMB considers CMS' data, the Medicare contractors that administer the demonstration, and AMRPA member reports, IRF compliance rates exceed 90%. Specifically, CMS' most recent published quarterly data (July 1 – September 30, 2024) found a program-wide affirmation rate of 91%, and a recent Novitas report on Cycle 2 in Pennsylvania (March 1 – May 31, 2025) rendered a 95.2% overall affirmation rate. AMRPA's analysis indicates that the small minority of claims that have not been affirmed 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. Given the very small percentage of claims that are subject to these types of disputes, the IRF RCD is an unnecessarily burdensome and costly method for attempting to clarify Medicare's IRF clinical coverage requirements.

Furthermore, there have also been a number of issues related to RCD transparency and oversight on the part of contractors that should be part of a wholistic RCD assessment. While the aforementioned CMS report certainly highlights IRFs' strong performance, AMRPA is disappointed that this data is now nearly a year old. We believe that more frequent and concurrent data reporting is critical for a program of this size, especially so that policymakers and oversight entities can make appropriate decisions on the RCD's continued operations.

Lastly, RCD contractors have created additional burdens to hospitals subject to the RCD with inconsistent compliance determinations and program updates. As an example, after numerous disputes about short stays, short stay transfers, and all cases with a length of stay of three days or less, the RCD contractors and CMS finally clarified which cases are excluded from the RCD. However, over the months when the definitions and resulting exclusions were not being administered consistently, IRFs had to submit more data and spend more time on these cases than should have been required. Specifically, because of the inconsistencies between Novitas and Palmetto's oversight of short stays, some providers received unnecessary additional documentation requests (ADRs) and inconsistent information about whether these cases would count towards the affirmation rate. While AMRPA is appreciative that the RCD contractors and CMS finally clarified which cases are excluded from the RCD, we believe these burdens and inconsistencies – for which short-stays were just one example - should be considered as the program is considered for expansion to other states and other contractors.

Given that the IRF RCD requires hospitals to submit all Medicare fee-for-service claims (for at least one cycle), these types of conflicting interpretation and subsequent program clarifications require extensive, mid-demonstration educational efforts and process updates. In light of the number of IRF coverage and documentation issues that have had to be corrected during the course of the demonstration, we believe these types of burdens must be factored into the RCD's justification assessment.

In conclusion, we believe there are numerous procedural, programmatic, and results-oriented issues that justify the termination of the IRF RCD. The program has failed to achieve its goals of identifying fraud or showing a need for improved compliance among IRFs, and the outstanding performance rates by IRFs clearly demonstrate that the costs and burdens created by the demonstration are not justified as the program approaches the two-year mark. When considering additional issues surrounding program transparency and oversight, we believe that termination is in the best interest of patients, the IRF sector, and CMS. The recent issues surrounding the IRF RCD's compliance with PRA requirements give OMB and CMS a timely and appropriate mechanism for ending the program, and we encourage your teams to take such action.

Should you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org, or Troy Hillman, AMRPA Director of Quality and Health Policy, at THillman@amrpa.org.

Sincerely,

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