DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 414

[CMS–1845–F]

RIN 0938–AV76

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2027. As required by statute, this final rule includes the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2027. It also finalizes the third and final of the 3-year phaseout of the rural adjustment, which began in FY 2025. This final rule includes a solicitation for public comments on alternative data sources for the IRF PPS wage index; requires all therapy treatments and/or therapy evaluations to begin no later than 36 hours from midnight on the day of admission; finalizes requirements for the initial Interdisciplinary Team meeting to occur on or before 4 days from the date the patient is admitted; and summarizes a request for information on potential future IRF PPS payment reform. Additionally, this final rule includes updates to the IRF Quality Reporting Program and changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

DATES: These regulations are effective on October 1, 2026.

FOR FURTHER INFORMATION CONTACT:

IRFcoverage@cms.hhs.gov, for general information.

Kimberly Schwartz, (410) 786–2571, for information about the IRF payment policies, payment rates and coverage policies.

Patricia Taft, (410) 786–4561, for readers who experience problems accessing online IRF–PPS documents.

Lauren Blum, (410) 786–9464, for information about the IRF quality reporting program.

Austin Gutowski, (410) 786–1643, for information about the DMEPOS CBP.

SUPPLEMENTARY INFORMATION:

Availability of Certain Information Through the Internet on the CMS Website

The IRF prospective payment system (IRF PPS) Addenda, along with other supporting documents and tables referenced in this final rule, are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation.* The technical reports that describe the analyses CMS conducted are referenced in the payment reform RFI (section IX. of this final rule) and can be found at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/research.*

We note that prior to 2020, each rule or notice issued under the IRF PPS included a detailed reiteration of the various regulatory provisions that have affected the IRF PPS over the years. That discussion, which has been updated to reflect subsequent years, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-legislative-history-updated-06-16-2025.pdf.*

I. Executive Summary

A. Purpose

This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for fiscal year (FY) 2027 (that is, for discharges occurring on or after October 1, 2026, and on or before September 30, 2027) under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by section 1886(j)(5) of the Act, this final rule includes the classification and weighting factors for the IRF PPS case-mix groups (CMGs), and a description of the methodologies and data used in computing the prospective payment rates for FY 2027. In addition, this final rule revises § 412.622(a)(3)(ii) to require all therapy treatments and/or therapy evaluations begin no later than 36 hours from midnight on the day of admission (hereafter referred to as the 36-hour requirement); and finalizes requirements for the initial Interdisciplinary Team (IDT) by revising § 412.622(a)(5) to require the initial meeting to occur on or before 4 days from the date the patient is admitted to align with the Plan of Care (POC) timeframe. We also provide summaries of the comments received in response to a Request for Information (RFI) on options to modernize and revise the primary diagnosis and comorbidity score methodology under the Skilled Nursing Facility Patient Driven Payment Model (PDPM) for the IRF PPS.

For the IRF Quality Reporting Program (QRP), this final rule revises the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. Finally, we provide summaries of the comments received in response to an RFI on future measure concepts for the IRF QRP.

For the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP), this rule finalizes a higher bid surety bond amount for a bidding entity submitting a bid in a Remote Item Delivery (RID) competitive bidding area.

B. Summary of Major Provisions

In this final rule, we use the methods described in the FY 2026 IRF PPS final rule (90 FR 37678) to update the prospective payment rates for FY 2027 using the most current and complete data available at this time, which is FY 2025 IRF claims and FY 2024 IRF cost report data, as discussed in section VI. of this final rule. In addition, this final rule revises the 36-hour requirement at § 412.622(a)(3)(ii) to require all therapy treatments and/or therapy evaluations begin no later than 36-hours from midnight on the day of admission; and it revises § 412.622(a)(5)(ii) to require that an initial IDT meeting must occur on or before 4 days from the date the patient is admitted to align with the POC timeframe.

We include summaries of comments received in response to an RFI on options to modernize the IRF PPS by leveraging and revising the primary diagnosis model and comorbidity score model used under the Skilled Nursing Facility Patient Driven Payment Model (SNF PDPM). Additionally, we include summaries of comments received on whether we should consider using alternative data sources to construct an IRF-specific wage index for potential use in future years to align with other CMS payment systems.

C. Summary of Impact

TABLE 1: Cost and Transfers

Provision Description	Transfers/Costs
FY 2027 IRF PPS payment rate update	The overall economic impact of this final rule is an estimated $340 million increase in payments from the Federal Government to IRFs during FY 2027.
FY 2027 IRF QRP changes	This final rule will not result in any costs or savings to IRFs related to the IRF QRP during FY 2027.

II. Background

A. Statutory Basis and Scope for IRF PPS Provisions

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. A complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880) and we provided a general description of the IRF PPS for FYs 2007 through 2019 in the FY 2020 IRF PPS final rule (84 FR 39055 through 39057). A general description of the IRF PPS for FYs 2020 through 2026, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation.*

Under the IRF PPS from FYs 2002 through 2005, the prospective payment rates were computed across 100 distinct CMGs, as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 and 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB's) Core-Based Statistical Area market definitions; modifications to the CMGs, tier comorbidities, and CMG relative weights; implementation of a new teaching status adjustment for IRFs; rebasing and revising the market basket used to update IRF payments; and updates to the rural, low-income percentage (LIP) and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs). Any reference to the FY 2006 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule.

The regulatory history previously included in each rule or notice issued under the IRF PPS, including a general description of the IRF PPS for FYs 2007 through 2026, is available on the CMS website at *https://www.cms.gov/files/document/irf-regulatory-legislative-history-updated-06-16-2025.pdf.*

B. Provisions of the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Affecting the IRF PPS in FY 2012 and Beyond

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient

Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the ''Affordable Care Act''.

The Affordable Care Act included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the Affordable Care Act also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for FY 2012 and each subsequent FY). The productivity adjustment for FY 2027 is discussed in section VI. of this final rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of the productivity adjustment to the market basket percentage increase may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY.

Section 3004(b) of the Affordable Care Act and section 411(b) of the MACRA (Pub. L. 114–10, enacted on April 16, 2015) also addressed the IRF PPS. Section 3004(b) of Affordable Care Act reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) of the Act and inserted a new section 1886(j)(7) of the Act, which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction to the IRF market basket percentage increase otherwise applicable to an IRF (after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a FY if the IRF does not comply with the requirements of the IRF QRP for that FY. Application of the 2-percentage point reduction may result in an update that is less than 0.0 for a FY and in payment rates for a FY being lower than payment rates for the preceding FY. Reporting-based reductions to the IRF market basket percentage increase are not cumulative; they only apply for the FY involved. Section 411(b) of the MACRA amended section 1886(j)(3)(C) of the Act by adding paragraph (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A fee-for-service (FFS) patient, the IRF is required to complete the appropriate sections of a Patient Assessment Instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762) and the FY 2010 IRF PPS correction notice (74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. A free download of the Grouper software is available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/software.* The Grouper software is also embedded in the internet Quality Improvement and Evaluation System (iQIES) User tool available in iQIES at *https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/internet-quality-improvement-evaluation-system-iqies.*

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, 110 Stat. 1936 August 21, 1996) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (ASCA) (Pub. L. 107–105, enacted on December 27, 2002) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once an MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. 100–04), hospitals (including IRFs) must submit to their MAC an informational-only bill (type of bill (TOB) 111) that includes Condition Code 04. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for FY 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR part 160 and part 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *https://www.cms.gov/medicare/coding-billing/electronic-billing/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The MAC processes the claim through its software system. This software system includes pricing programming called the ''Pricer'' software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in

the FY 2006 IRF PPS final rule (70 FR 47880).

III. Summary of Provisions of the Final Rule

In this FY 2027 IRF PPS final rule, we are finalizing our proposal to update the IRF PPS for FY 2027 and the IRF QRP for FY 2027 and FY 2029.

The finalized policy changes and updates to the IRF prospective payment rates for FY 2027 will be as follows:

- Update the CMG relative weights and average length of stay values for FY 2027 in a budget neutral manner, as discussed in section IV. of this final rule.
- Update the IRF PPS payment rates for FY 2027 by the IRF market basket percentage increase, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this final rule.
- Update the FY 2027 IRF PPS payment rates by the FY 2027 wage index, applying the final year of the phase-out of the rural adjustment for IRFs transitioning from rural to urban, and the labor-related share in a budget-neutral manner, as discussed in section V. of this final rule.
- Summarize public comments received on alternative data sources for the wage index, as discussed in section V. of this final rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2027, as discussed in section V. of this final rule.
- Update the outlier threshold amount for FY 2027, as discussed in section VII. of this final rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2027, as discussed in section VII. of this final rule.
- Require all therapy treatments and/or therapy evaluations to begin no later than 36-hours from midnight on the day of admission (§ 412.622(a)(3)(ii)), as discussed in section VII. of this final rule.
- Not finalize the proposal to require the patient's current functional status is documented in the preadmission screening (§ 412.622(a)(4)(i)(B)), as discussed in section VII. of this final rule.
- Require the initial IDT meeting to occur on or before 4 days from the date the patient is admitted and align with the POC timeframe (§ 412.622(a)(5)(ii)), as discussed in section VII. of this final rule.
- Summarize public comments on the RFI on updating the IRF payment system to explore options to modernize the IRF PPS by leveraging the existing clinical classification and comorbidity score methodology used by the SNF PDPM to group patients by case mix, as discussed in section VIII. of this final rule.

The finalized policy change and update to the IRF QRP for FY 2029 is as follows:

- Revise the IRF QRP data submission deadlines.

The finalized policy change and update to the DMEPOS Competitive Bidding Program (CBP) is as follows:

- Update the bid surety bond requirement to require a higher bid surety bond amount for a bidding entity submitting a bid under a Remote Item Delivery competitive bidding program.

IV. Analysis and Responses to Public Comments

We received 103 timely pieces of correspondence from the public, many of which contained multiple comments on the FY 2027 IRF PPS proposed rule (91 FR 17195). We received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, healthcare industry organizations, healthcare consulting and patient advocacy firms, technology vendors, academic institutions, and anonymous persons. The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

A. General Comments on the FY 2027 IRF PPS Proposed Rule

In addition to the comments we received on specific proposals contained within the proposed rule (which we address later in this final rule), commenters also submitted more general observations on the IRF PPS and IRF care generally.

Comment: We received a couple of comments on the facility-level payment adjustments that recommend CMS revise the adjustments. A commenter stated that the current low-income patient (LIP) adjustment does not adequately support high-share low-income patient facilities, citing continued negative Medicare margins for facilities with high LIP share, and requested CMS reexamine and report on the adjustment's effectiveness for FY 2028. Another commenter expressed that CMS should update the LIP and Rural coefficients using a rolling 3-year average, cap the teaching adjustment at IPPS levels, and phase in any changes over 2 to 3 years if implemented in FY 2027. Overall, both commenters stated that the current payment adjustments may not accurately reflect cost pressures faced by low-income and teaching IRFs, which necessitates the need for recalibration to better align payments with patient mix and resource needs.

Response: We thank the commenters regarding the facility level adjustments and their effect on IRFs serving low-income and teaching IRFs. As discussed in the FY 2015 IRF PPS final rule (79 FR 45883), we finalized freezing the facility-level adjustment factors for FY 2014 and all subsequent years (unless and until we propose to update them again through future notice and comment rulemaking). Specifically, the rural adjustment of 14.9 percent, a LIP adjustment factor of 0.3177, and a teaching status adjustment factor of 1.0163 have been frozen since FY 2014. We will consider potential policy refinements as we monitor the adjustment going forward. The low-income patient (LIP) and rural adjustment will continue to be applied according to current policy for FY 2027 as we did not propose to change these adjustments in this rule.

V. Updates to the CMG Relative Weights and Average Length of Stay (ALOS) Values for FY 2027

As specified in § 412.620(b)(1), an appropriate weight is assigned to each CMG that measures the relative difference in facility resource intensity among the various case-mix groups. In other words, we calculate a relative weight for each CMG that is proportional to the resources needed for an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this final rule, we update the CMG relative weights and average length of stay (ALOS) values for FY 2027. Typically, we use the most recent available data to update the CMG relative weights and ALOS values. For FY 2027, we use the FY 2025 IRF claims and FY 2024 IRF cost report data (CMS Form 2552–10, OMB No 0938–0050). These data are the most current and complete data available at the time of this final rule. Currently, only a small portion of the FY 2025 IRF cost report data is available for analysis, but the majority of the FY 2025 IRF claims data are available for analysis.

In the FY 2027 IRF PPS proposed rule, we proposed that if more recent

data became available after the publication of the proposed rule and before the publication of the final rule, we would use such data to determine the FY 2027 CMG relative weights and ALOS values in the final rule.

We proposed to apply these data using the same methodologies that we have used to update the CMG relative weights and ALOS values each FY since we implemented an update to the methodology. The detailed CCR data from the cost reports of IRF provider units of primary acute care hospitals is used for this methodology, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate the operating (routine and ancillary services) and capital costs of IRFs. The process to calculate the CMG relative weights for this final rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in Step 1.

Step 3. We use the adjusted costs from Step 2 to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2027 CMG relative weights using a normalization factor that results in the average CMG relative weights in FY 2027 being the same as the average CMG relative weights in the FY 2026 IRF PPS final rule (90 FR 37678).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are updating the CMG relative weights for FY 2027 in such a way that total estimated aggregate payments to IRFs for FY 2027 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2027 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2027 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2027 by applying the proposed changes to the CMG relative weights (as discussed in the proposed rule).

Step 3. Divide the amount calculated in Step 1 by the amount calculated in Step 2 to determine the budget neutrality factor of 0.9990 that would maintain the same total estimated aggregate payments in FY 2027 with and without the proposed changes to the final CMG relative weights.

Step 4. Apply the budget neutrality factor from Step 3 to the FY 2027 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V. of this final rule, we discuss the use of the existing methodology to calculate the proposed standard payment conversion factor for FY 2027.

In Table 2, ''Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the CMGs, the comorbidity tiers, the corresponding relative weights, and the ALOS values for each CMG and tier for FY 2027. The ALOS for each CMG is used to determine when an IRF discharge meets the definition of a short stay transfer, which results in a per diem case level adjustment.

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TABLE 2: Relative Weights and Average Length of Stay Values for the Case-Mix Groups

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0101	Stroke M >=72.50	0.9840	0.8444	0.7705	0.7390	9	9	9	8
0102	Stroke M >=63.50 and M <72.50	1.2541	1.0761	0.9820	0.9418	11	11	10	10
0103	Stroke M >=50.50 and M <63.50	1.6068	1.3788	1.2582	1.2067	13	14	13	13
0104	Stroke M >=41.50 and M <50.50	2.0342	1.7456	1.5929	1.5277	17	17	16	16
0105	Stroke M <41.50 and A >=84.50	2.5889	2.2216	2.0272	1.9443	21	22	19	19
0106	Stroke M <41.50 and A <84.50	2.9548	2.5356	2.3137	2.2190	24	24	22	22
0201	Traumatic brain injury M >=73.50	1.1165	0.8808	0.8082	0.7579	10	9	9	8
0202	Traumatic brain injury M >=61.50 and M <73.50	1.3798	1.0885	0.9988	0.9366	11	12	11	10
0203	Traumatic brain injury M >=49.50 and M <61.50	1.7322	1.3664	1.2539	1.1758	14	14	13	12
0204	Traumatic brain injury M >=35.50 and M <49.50	2.1428	1.6903	1.5511	1.4545	17	17	15	15
0205	Traumatic brain injury M <35.50	2.7719	2.1865	2.0065	1.8815	27	22	19	18
0301	Non-traumatic brain injury M >=65.50	1.2273	0.9413	0.8841	0.8178	10	9	9	9
0302	Non-traumatic brain injury M >=52.50 and M <65.50	1.5788	1.2109	1.1373	1.0521	13	12	11	11
0303	Non-traumatic brain injury M >=42.50 and M <52.50	1.9169	1.4702	1.3808	1.2774	15	14	13	13
0304	Non-traumatic brain injury M <42.50 and A >=78.50	2.2496	1.7254	1.6205	1.4991	18	16	15	15
0305	Non-traumatic brain injury M <42.50 and A <78.50	2.4408	1.8720	1.7582	1.6265	20	18	17	16
0401	Traumatic spinal cord injury M >=56.50	1.3059	1.1286	1.0544	0.9613	13	12	11	11
0402	Traumatic spinal cord injury M >=47.50 and M <56.50	1.6279	1.4070	1.3144	1.1984	14	13	14	13
0403	Traumatic spinal cord injury M >=41.50 and M <47.50	2.0643	1.7841	1.6667	1.5196	18	17	17	16
0404	Traumatic spinal cord injury M <31.50 and A <61.50	3.1280	2.7035	2.5256	2.3027	24	31	25	18
0405	Traumatic spinal cord injury M >=31.50 and M <41.50	2.5612	2.2136	2.0679	1.8854	23	21	20	20
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50	3.2074	2.7722	2.5897	2.3611	26	28	24	25
0407	Traumatic spinal cord injury M <24.50 and A >=61.50	4.4884	3.8793	3.6240	3.3041	53	37	32	32
0501	Non-traumatic spinal cord injury M >=60.50	1.2680	1.0034	0.9438	0.8786	12	10	10	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50	1.5561	1.2314	1.1582	1.0783	13	12	12	12

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50	1.7552	1.3890	1.3064	1.2162	14	14	13	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50	2.1116	1.6710	1.5717	1.4632	19	16	15	15
0505	Non-traumatic spinal cord injury M <39.50	2.9563	2.3396	2.2005	2.0486	24	22	21	20
0601	Neurological M >=64.50	1.3670	1.0009	0.9320	0.8547	10	10	9	9
0602	Neurological M >=52.50 and M <64.50	1.7012	1.2456	1.1598	1.0636	13	12	11	11
0603	Neurological M >=43.50 and M <52.50	1.9963	1.4617	1.3610	1.2481	15	14	13	13
0604	Neurological M <43.50	2.5173	1.8432	1.7162	1.5738	19	17	16	15
0701	Fracture of lower extremity M >=61.50	1.2512	0.9661	0.9064	0.8400	10	10	10	9
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.5542	1.2000	1.1258	1.0434	12	12	12	11
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.9322	1.4919	1.3997	1.2972	15	15	14	13
0704	Fracture of lower extremity M <41.50	2.3857	1.8420	1.7282	1.6016	19	18	17	16
0801	Replacement of lower-extremity joint M >=63.50	1.2013	0.9653	0.8845	0.8402	10	9	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3646	1.0965	1.0047	0.9543	11	11	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.5066	1.2106	1.1093	1.0536	12	11	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.7149	1.3780	1.2627	1.1993	14	13	12	12
0805	Replacement of lower-extremity joint M <42.50	2.1041	1.6907	1.5492	1.4715	17	16	15	14
0901	Other orthopedic M >=63.50	1.2051	0.9364	0.8840	0.8192	10	10	9	9
0902	Other orthopedic M >=51.50 and M <63.50	1.5311	1.1898	1.1232	1.0408	12	12	11	11
0903	Other orthopedic M >=44.50 and M <51.50	1.8068	1.4040	1.3254	1.2282	14	13	13	13
0904	Other orthopedic M <44.5	2.1986	1.7085	1.6129	1.4945	17	16	16	15
1001	Amputation lower extremity M >=64.50	1.2123	1.0256	0.9170	0.8331	10	11	10	9
1002	Amputation lower extremity M >=55.50 and M <64.50	1.4955	1.2651	1.1312	1.0277	13	12	12	11
1003	Amputation lower extremity M >=47.50 and M <55.50	1.8249	1.5438	1.3804	1.2540	15	14	14	13
1004	Amputation lower extremity M <47.50	2.3320	1.9727	1.7640	1.6025	18	19	17	16
1101	Amputation non-lower extremity M >=58.50	1.2244	1.0493	1.0088	0.8971	10	11	11	9
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.5710	1.3463	1.2943	1.1510	12	13	13	10

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1103	Amputation non-lower extremity M <52.50	1.9470	1.6685	1.6041	1.4265	18	15	16	12
1201	Osteoarthritis M >=61.50	1.1403	0.9834	0.8936	0.8380	10	10	9	9
1202	Osteoarthritis M >=49.50 and M <61.50	1.4187	1.2235	1.1118	1.0426	12	14	11	11
1203	Osteoarthritis M <49.50 and A >=74.50	1.8950	1.6343	1.4851	1.3926	15	16	15	14
1204	Osteoarthritis M <49.50 and A <74.50	1.8825	1.6235	1.4753	1.3834	16	15	15	13
1301	Rheumatoid other arthritis M >=62.50	1.1941	0.9173	0.9079	0.8282	10	7	9	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.5770	1.2114	1.1990	1.0938	13	12	11	11
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.8230	1.4004	1.3860	1.2644	15	13	13	13
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.2795	1.7510	1.7331	1.5810	16	18	16	15
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.1614	1.6603	1.6433	1.4991	16	15	16	15
1401	Cardiac M >=68.50	1.1244	0.9033	0.8245	0.7556	10	9	9	8
1402	Cardiac M >=55.50 and M <68.50	1.4297	1.1485	1.0484	0.9607	12	11	10	10
1403	Cardiac M >=45.50 and M <55.50	1.7412	1.3988	1.2769	1.1701	14	13	12	12
1404	Cardiac M <45.50	2.1229	1.7054	1.5568	1.4266	18	16	15	14
1501	Pulmonary M >=68.50	1.3297	1.0507	0.9939	0.9370	12	10	9	9
1502	Pulmonary M >=56.50 and M <68.50	1.6569	1.3093	1.2384	1.1676	13	12	11	11
1503	Pulmonary M >=45.50 and M <56.50	1.8972	1.4991	1.4180	1.3369	14	13	13	12
1504	Pulmonary M <45.50	2.3451	1.8531	1.7528	1.6525	19	17	15	15
1601	Pain syndrome M >=65.50	1.1594	0.8862	0.8052	0.7377	9	9	9	8
1602	Pain syndrome M >=58.50 and M <65.50	1.3972	1.0681	0.9704	0.8891	11	11	10	10
1603	Pain syndrome M >=43.50 and M <58.50	1.8108	1.3842	1.2576	1.1522	13	14	13	13
1604	Pain syndrome M <43.50	2.3324	1.7830	1.6199	1.4841	15	16	16	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.4146	1.0364	0.9600	0.8916	11	10	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.7530	1.2844	1.1896	1.1049	14	14	12	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	2.0456	1.4988	1.3882	1.2893	16	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.3387	1.7135	1.5871	1.4740	18	17	15	15

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.7867	2.0417	1.8911	1.7564	22	19	18	17
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.1494	0.9172	0.8529	0.7868	10	11	9	9
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.4488	1.1561	1.0750	0.9918	13	12	11	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.8351	1.4644	1.3617	1.2562	14	15	14	13
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	2.0710	1.6526	1.5367	1.4177	17	16	15	15
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.5062	1.9999	1.8597	1.7156	22	20	18	17
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.5548	2.8366	2.6378	2.4334	38	27	24	23
1901	Guillain-Barré M >=66.50	1.0733	0.9529	0.8489	0.8266	13	11	9	9
1902	Guillain-Barré M >=51.50 and M <66.50	1.5683	1.3924	1.2404	1.2078	18	15	13	12
1903	Guillain-Barré M >=38.50 and M <51.50	2.2393	1.9881	1.7711	1.7245	23	19	17	18
1904	Guillain-Barré M <38.50	3.3989	3.0177	2.6883	2.6175	37	29	25	25
2001	Miscellaneous M >=66.50	1.2079	0.9497	0.8735	0.8112	10	10	9	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4961	1.1763	1.0819	1.0048	12	11	11	10
2003	Miscellaneous M >=46.50 and M <55.50	1.7739	1.3947	1.2828	1.1913	14	14	13	12
2004	Miscellaneous M <46.50 and A >=77.50	2.1382	1.6811	1.5462	1.4360	17	16	15	15
2005	Miscellaneous M <46.50 and A <77.50	2.2762	1.7895	1.6460	1.5286	18	17	16	15
2101	Burns M >=52.50	1.6233	1.3063	1.2264	1.0448	11	15	13	11
2102	Burns M <52.50	2.4574	1.9776	1.8566	1.5817	14	20	18	15
5001	Short-stay cases, length of stay is 3 days or fewer	0.0000	0.0000	0.0000	0.1759	0	0	0	3
5101	Expired, orthopedic, length of stay is 13 days or fewer	0.0000	0.0000	0.0000	0.8653	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more	0.0000	0.0000	0.0000	1.9494	0	0	0	18
5103	Expired, not orthopedic, length of stay is 15 days or fewer	0.0000	0.0000	0.0000	0.9515	0	0	0	9
5104	Expired, not orthopedic, length of stay is 16 days or more	0.0000	0.0000	0.0000	2.2711	0	0	0	20

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Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 3 shows how we

estimate that the application of the proposed revisions for FY 2027 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. We note that, because we implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2027 would not be affected as a result of the CMG relative weight revisions. However, the revisions will affect the distribution of payments within CMGs and tiers.

TABLE 3: Distributional Effects of the Changes to the CMG Relative Weights

Percentage Change in CMG Relative Weights	Number of Cases Affected	Percentage of Cases Affected
Increased by 15% or more	128	0.0%
Increased by between 5% and 15%	1,824	0.4%
Changed by less than 5%	470,128	99.4%
Decreased by between 5% and 15%	633	0.1%
Decreased by 15% or more	44	0.0%

As shown in Table 3, 99.4 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2027. The changes in the ALOS values for FY 2027, compared with the FY 2026 ALOS values, are small and do not show any particular trends in IRF length of stay patterns.

The methodology that we use to update the CMG relative weights uses the most recent cost data reported by IRFs to compute relative weights that reflect the relative costliness of different IRF cases in a budget neutral manner. We increase or decrease relative weights of the CMGs annually, including for those CMGs associated with the 13 conditions that qualify for the 60 percent rule, under 42 CFR 412.29(b)(2), based only on the cost data reported to us by IRFs each year. We believe that these data accurately reflect the severity of the IRF patient population and the associated costs of caring for these patients in the IRF setting. The CMG relative weights are updated each year based on the most recent available data for the full population of IRF Medicare fee-for-service beneficiaries. This ensures that the IRF case-mix system is as reflective as possible of changes in the IRF patient populations and the associated coding practices and ensures that IRF payments appropriately reflect the relative costs of caring for all types of IRF patients.

We received public comments on our proposed updates to the CMG relative weights and ALOS values for FY 2027. The following is a summary of the comments we received and our responses.

Comment: A few commenters submitted feedback on the updates to the CMG relative weights and ALOS values, all in support of the proposed updates. Commenters encouraged continued updates in the final rule, supported using most recent available data, and stated that the vast majority of IRF cases would not be changed by the proposed update.

Response: We appreciate these commenters' support for updating the relative weights and ALOS values for FY2027. We have updated our data between the FY 2027 IRF PPS proposed and this final rule to ensure that we use the most recent available data in calculating IRF PPS payments.

As discussed earlier in this section of this final rule, the methodology that we use to update the CMG relative weights uses the most recent cost data reported by IRFs to compute relative weights that reflect the relative costliness of different IRF cases in a budget neutral manner. We increase or decrease relative weights of the CMGs annually, including for those CMGs associated with the 13 conditions that qualify for the 60 percent rule, under 42 CFR 412.29(b)(2) based only on the cost report data reported to us by IRFs each year.

We believe that these data accurately reflect the severity of the IRF patient population and the associated costs of caring for these patients in the IRF setting. The CMG relative weights are updated each year based on the most recent available data for the full population of IRF Medicare fee-for-service beneficiaries. This ensures that the IRF case-mix system is as reflective as possible of changes in the IRF patient population and the associated coding practices and ensures IRF payments appropriately reflect the relative costs of caring for all types of IRF patients.

After consideration of the comments we received, we are finalizing our proposal to update the CMG relative weights and ALOS values for FY 2027 using the same methodologies that we have used to update the CMG relative weights and ALOS values for each FY since we implemented an update to the methodology in FY 2009, as shown in Table 3 of this final rule. These updates are effective for FY 2027, that is, for discharges occurring on or after October 1, 2026, and on or before September 30, 2027. CMS is finalizing Table 2: Relative Weights and Average Length of Stay Values for Case-Mix Groups and Table 3: Distributional Effects of the Changes to the CMG Relative Weights as proposed with the most recent available data.

VI. FY 2027 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Thus, we are updating the IRF PPS payments for FY 2027 by a market basket percentage increase as required by section 1886(j)(3)(C) of the Act based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We have utilized various market baskets through the years in the IRF PPS. For a discussion of these market baskets, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47046).

Beginning with FY 2024, we finalized a rebased and revised IRF market basket to reflect a 2021 base year. The FY 2024 IRF PPS final rule (88 FR 50966 through 50988) contains a complete discussion

of the development of the 2021-based IRF market basket.

B. FY 2027 Market Basket Update and Productivity Adjustment

1. FY 2027 Market Basket Update

For FY 2027 (that is, beginning October 1, 2026, and ending September 30, 2027), we proposed to update the IRF PPS payments by a market basket percentage increase as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. For FY 2027, we proposed to use the same methodology described in the FY 2026 IRF PPS final rule (90 FR 37687 through 37691).

Consistent with historical practice, we proposed to estimate the market basket update for the IRF PPS for FY 2027 based on the most recently available data at the time of rulemaking. Based on IHS Global Inc.'s (IGI) fourth quarter 2025 forecast with historical data through the third quarter of 2025 the proposed 2021-based IRF market basket percentage increase for FY 2027 was projected to be 3.2 percent. IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the FY 2027 IRF market basket update in the final rule. Based on IGI's second quarter 2026 forecast with historical data through the first quarter of 2026, the 2021-based IRF market basket percentage increase for FY 2027 is 3.2 percent.

2. FY 2027 Productivity Adjustment

Section 1886(j)(3)(C)(ii) of the Act requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period; the ''productivity adjustment'').

The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the U.S. economy. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is published by BLS as private nonfarm business total factor productivity (TFP) previously referred to as multifactor productivity.[1] We refer readers to *https://www.bls.gov/productivity/* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information.*

As stated in the proposed rule, using IGI's fourth quarter 2025 forecast, the 10-year moving average growth of TFP for FY 2027 was projected to be 0.8 percent. In accordance with section 1886(j)(3)(C) of the Act, we proposed to base the FY 2027 IRF market basket percentage increase, which is used to determine the applicable percentage increase for the IRF payments, on IGI's fourth quarter 2025 forecast of the 2021-based IRF market basket. We proposed to then reduce the market basket percentage increase by the proposed productivity adjustment for FY 2027 of 0.8 percentage point (the 10-year moving average growth of TFP for the period ending FY 2027 based on IGI's fourth quarter 2025 forecast). Therefore, the proposed FY 2027 IRF market basket update was 2.4 percent (3.2 percent IRF market basket percentage increase reduced by the 0.8 percentage point productivity adjustment). Furthermore, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket percentage increase and productivity adjustment), we would use such data, if appropriate, to determine the FY 2027 IRF market basket percentage increase and productivity adjustment in this final rule.

Thus, using IGI's second quarter 2026 forecast, the 10-year moving average growth of TFP for FY 2027 is projected to be 0.9 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, the FY 2027 market basket percentage increase, which is used to determine the applicable percentage increase for the IRF payments, is equal to 3.2 percent using IGI's second quarter 2026 forecast of the 2021-based IRF market basket. We then reduce this percentage increase by the estimated productivity adjustment for FY 2027 of 0.9 percentage point (the 10-year moving average growth of TFP for the period ending FY 2027 based on IGI's second quarter 2026 forecast). Therefore, more recent data would provide a FY 2027 IRF update equal to 2.3 percent (3.2 percent IRF market basket percentage increase reduced by the 0.9 percentage point productivity adjustment).

In its March 2026 Report to Congress, MedPAC recommended that Congress should reduce the IRF PPS base payment rate by 7 percent for FY 2027.[2] As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary proposed to update the IRF PPS payment rates for FY 2027 by the proposed IRF market basket update of 2.4 percent. Based on more recent data, the current estimate of the productivity-adjusted IRF market basket increase factor for FY 2027 is 2.3 percent. Section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2027.

We invited public comments on our proposals for the FY 2027 market basket percentage increase and productivity adjustment. The following is a summary of the public comments received and our responses.

Comment: Many commenters expressed concern that the FY 2027 proposed payment update is insufficient. Commenters stated that the proposed payment update does not reflect cost increases faced by IRFs over the last few years, specifically citing cost increases such as wages and contract labor, prescription drugs, medical supplies, technology PPE, and capital investment. Other challenges highlighted by commenters included inflation, staffing shortages, recruitment and retention challenges, documentation demands, payer-related administrative burden and increased patient acuity.

Several commenters appreciated the proposed update, with some commenters stating that the proposed update does not resolve the broader fiscal pressures facing IRFs. Some commenters supported finalizing the FY 2027 IRF PPS payment update as proposed. Many of the commenters encouraged CMS to continue monitoring whether future payment updates

[1] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

[2] Medicare Payment Advisory Commission. *March 2026 Report to the Congress: Medicare Payment Policy. Accessed at: https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf.*

adequately reflect sustained real-world cost pressures facing IRFs. A commenter also urged CMS to monitor the financial viability of IRFs and take additional steps to support their sustainability.

Several commenters urged CMS to finalize a higher payment update for FY 2027 or consider adjustments to reconsider the proposed update. Some commenters encouraged CMS to consider recommendations to Congress, as appropriate, or to evaluate all available data sources and policy options to better align payment updates with providers' actual cost experience.

A commenter claimed that a significant contributor to fiscal instability is the persistent gap between Medicare reimbursement and the actual cost of care. The commenter stated that closer alignment between the market basket update and the actual cost of furnishing care to Medicare beneficiaries is essential to meeting CMS' statutory obligation to ensure payment adequacy. Some commenters stated that the CMS IRF rate setting file suggests that over 33 percent of IRFs would be projected to face negative Medicare profit margins for FY 2027.

Some commenters encouraged CMS to continue evaluating whether the IRF market basket adequately reflects the current cost structure associated with furnishing modern inpatient rehabilitation care. A commenter stated that the IRF market basket relies on projected growth in generalized hospital goods and services, which does not consider the specialized training and experience required by therapists, nurses, and other clinicians in IRFs. Additionally, the commenter noted that IRFs often incur higher costs for advanced rehabilitation technologies and specialized drugs, which may not be adequately reflected in the market basket. The commenter urged CMS to explore all available avenues to update IRF PPS payments in a manner that addresses rising costs and reductions in reimbursement to ensure there are no disruptions in access to IRF services for Medicare beneficiaries.

A commenter requested that CMS, in the final rule, make use of the most current available data when finalizing the market basket forecast and clearly explain in the final rule the basis on which CMS concludes the update is sufficient to preserve beneficiary access to medically appropriate IRF placement, particularly for high-acuity patients discharged from hospitals. A commenter urged CMS to revisit its market basket forecast and to work with Congress to reduce the magnitude of the productivity adjustment, as well as consider their combined effect on reimbursements for hospitals. Another commenter urged CMS to carefully review inflation trends in light of recent growth and projected volatility so as to avoid a significant understatement of market-basket changes in FY 2027, much like occurred in FY 2022.

Response: We acknowledge and appreciate commenters' concerns regarding recent trends in inflation. We are required to update IRF PPS payments by the market basket update adjusted for productivity, as directed by section 1886(j)(3)(C) of the Act. Specifically, section 1886(j)(3)(C)(i) of the Act states that the increase factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made. In the FY 2024 IRF PPS final rule, we rebased the IRF market basket to reflect a 2021 base year (88 FR 50966 through 50982). We believe the increase in the 2021-based IRF market basket adequately reflects the average change in the price of goods and services hospitals purchase to provide IRF medical services and is technically appropriate to use as the IRF payment update factor.

The IRF market basket is a fixed-weight, Laspeyres-type index that measures the change in price over time of the same mix of goods and services purchased by IRFs in the base period. As we discussed in response to similar comments in the FY 2024 IRF PPS final rule (88 FR 50983), the FY 2025 IRF PPS final rule (89 FR 64286), and the FY 2026 IRF PPS final rule (90 FR 37689), the IRF market basket update would reflect the prospective price pressures described by the commenters as increasing during a high inflation period but would inherently not reflect other factors that might increase the level of costs (such as increases in volume or intensity). We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased and the base year weights are updated to a more recent time period.

We disagree that the IRF market basket does not consider the specialized costs faced by IRFs, as the market basket weights are derived directly from IRF cost report data, which inherently captures and reflects the specific cost structures of inpatient rehabilitation facilities, including expenditures for specialized rehabilitation technologies, advanced therapeutic equipment, and the unique staffing mix required for IRF services, ensuring that these facility-specific costs are appropriately represented in the market basket calculation. Additionally, we note that the IRF market basket is designed to reflect national-level inflationary price pressures affecting IRFs, and separate payment adjustments, such as rural add-on payments and wage index adjustments, exist to address geographic cost variations and specific challenges faced by rural facilities. Therefore, we believe the 2021-based IRF market basket appropriately reflects IRF cost structures.

To measure price growth for IRF wages and salaries costs in the IRF market basket, since IRF-specific information is unavailable, we use the Employment Cost Index (ECI) for Wages and Salaries for All Civilian workers in Hospitals. As stated in the FY 2024 IRF final rule (88 FR 50978), FY 2025 IRF final rule (89 FR 64286), and FY 2026 IRF final rule (90 FR 37690) we believe that this ECI is the best available price proxy to account for the occupational skill mix within IRFs and in the absence of an IRF-specific ECI, we believe that the highly skilled hospital workforce captured by the ECI for Wages and Salaries for All Civilian workers in Hospitals (inclusive of therapists, nurses, other clinicians, etc.) is a reasonable price proxy for the compensation components of the IRF market basket. The FY 2024 IRF and FY 2025 IRF final rules provide a detailed discussion as it relates to contract labor in IRFs and their share of overall IRF compensation costs and hours.

To reflect expected price growth for each of the cost categories in the IRF market basket, we rely on impartial economic forecasts of the price proxies used in the market basket from IGI, which is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. At the time of the FY 2027 IRF PPS proposed rule, based on IGI's fourth quarter 2025 forecast with historical data through the third quarter of 2025, the 2021-based IRF market basket update was forecasted to be 3.2 percent for FY 2027, reflecting forecasted compensation price growth of 3.3 percent. We also note that when developing its forecast for labor prices, IGI considers overall labor market conditions (including rise in contract labor employment due to tight labor market conditions) as well as trends in contract labor wages, which both have an impact on wage pressures for workers employed directly by the hospital.

As is our general practice, in the FY 2027 IRF PPS proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final

FY 2027 IRF market basket update for the final rule. For this final rule, we now have an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy and expected price inflation for FY 2027. Based on IGI's second quarter 2026 forecast with historical data through the first quarter of 2026, we are projecting a FY 2027 IRF market basket percentage increase of 3.2 percent (reflecting forecasted compensation price growth of 3.2 percent), which is the same as in the proposed rule. Based on IGI's second quarter 2026 forecast, we are also projecting a productivity adjustment of 0.9 percent that is 0.1 percentage point higher than in the proposed rule, primarily due to the incorporation of historical TFP data from BLS. Therefore, for FY 2027 a final IRF market basket update of 2.3 percent (3.2 percent less 0.9 percentage point) will be applicable, which is slightly lower than the proposed IRF market basket update of 2.4 percent.

Regarding whether IRF PPS payments are adequate to cover costs, MedPAC's analysis and recommendations as published in MedPAC's March 2026 Report to Congress [3] concluded that Medicare's current payment rates for IRFs are more than adequate based on aggregate Medicare margins above 13 percent since 2015. With respect to the commenters' concern about payments to non-profits, MedPAC acknowledged that margins continued to vary widely across types of IRFs, with higher margins in IRFs that were freestanding, for profit, urban, larger, and with a greater share of FFS Medicare days.

Comment: Several commenters had concerns regarding the application and magnitude of the productivity adjustment. Some commenters requested that CMS use its ''special exceptions and adjustments'' authority to eliminate or reduce the 0.8 percentage point productivity cut for FY 2027.

Some commenters requested that CMS work with Congress to reduce the magnitude of the productivity adjustment. A commenter noted that they find it troubling that the productivity adjustment appears to be applied only when it reduces Medicare payments. Another commenter requested that CMS carefully monitor the impact that the productivity adjustments have on the inpatient rehabilitation hospital sector, provide feedback to Congress as appropriate, and consider modifying the productivity adjustment consistent with the actual experiences of IRFs. While another commenter urged CMS to provide clarification in order for interested parties to provide feedback on the productivity adjustment. Another commenter requested that CMS in the final rule carefully reassess whether the 0.8 percentage-point productivity adjustment is supportable in light of the post-pandemic operating environment.

A commenter urged CMS to reexamine whether the productivity adjustment is consistent with the agency's own findings on hospital sector productivity. The commenter recognized that the productivity adjustment is required by section 1886(j)(3)(C)(ii)(I) of the Social Security Act, and that the statute does not provide CMS unilateral authority to set the adjustment at zero. The commenter stated that the statute does not, however, require CMS to disregard the documented mismatch between the offset and OACT's own analysis of hospital sector productivity. The commenter urged CMS to work with Congress to modify the statute to focus on adjustments based on productivity changes in hospitals rather than private nonfarm businesses. The commenter also urged CMS to engage OACT and the relevant offices within the Department of Health and Human Services in reexamining whether the methodology currently used to compute the productivity adjustment is consistent with the agency's own analytical findings about hospital sector productivity.

Response: Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment, described in section 1886(b)(3)(B)(xi)(II), to the IRF PPS market basket increase factor. As required by statute, the FY 2027 productivity adjustment is derived based on the 10-year moving average growth in economy-wide, private nonfarm business total factor productivity for the period ending FY 2027. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, as we explained in response to similar comments in the FY 2023, FY 2024, FY 2025, and FY 2026 IRF PPS final rules, we are required under section 1886(j)(3)(C)(ii)(I) of the Act to apply the specific productivity adjustment described here.

We have always made available on the CMS website the general method for calculating the productivity adjustment. This includes providing a link (*https://www.bls.gov/productivity/*) to the most recent BLS historical TFP data, which currently allows interested parties to obtain historical TFP annual index levels for 1987 through 2025. We also provided the IGI projection model (*https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf*), which for this final rule is used to derive annual TFP growth rates for 2026 and 2027. The annual index level derived from this method is then interpolated to quarterly levels, and the FY 2027 productivity adjustment is equal to the percent change in the 40-quarter moving average projected level for the period ending September 30, 2027, relative to the 40-quarter moving average projected level for the period ending September 30, 2026. We believe our methodology for the productivity adjustment is consistent with section 1886(b)(3)(B)(xi)(II) of the Act, which states that the productivity adjustment is equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period).

At the time of this final rule, the 2027 productivity adjustment reflects BLS historical TFP data through 2025 (released on March 19, 2026) and IGI's forecasted TFP growth for 2026 and 2027. The average annual growth rate of historical TFP published by BLS for 2018 through 2025 is currently 1.0 percent and IGI is projecting average TFP growth of about 0.7 percent for 2026 and 2027 based on IGI's second-quarter 2026 forecast. Combining the historical and projected TFP data over the entire 10-year time period and interpolating into quarterly index levels results in a 10-year moving average growth rate of TFP of 0.9 percent for FY 2027. The productivity adjustment (based on the 10-year period ending with FY 2027) for the FY 2027 final rule is 0.1 percentage point higher than the FY 2027 IRF proposed rule mainly due to the incorporation of updated BLS historical data.

In response to commenters' concerns about the productivity adjustment only being applied if it reduces the payment update, as noted in the FY 2026 IRF final rule (90 FR 37691), the productivity adjustment was established under the Affordable Care Act with a specific policy intent to encourage efficiency improvements in healthcare

[3] Medicare Payment Advisory Commission. *March 2026 Report to the Congress: Medicare Payment Policy. Accessed at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf.*

delivery by linking Medicare payment updates to economy-wide productivity gains. The statutory language in section 1886(j)(3)(C)(ii) of the Act requires that the Secretary reduce (not increase) the market basket percentage increase factor by changes in economy-wide productivity, therefore, only positive productivity adjustments are applied.

Comment: A commenter urged CMS to use its special exceptions and adjustments authority to implement a one-time, retrospective adjustment of 3.8 percentage points to account for the underpayments that occurred between FY 2022 and FY 2024, in addition to the proposed FY2027 market basket update.

Response: The IRF market basket updates are set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2027 market basket update in this final rule reflects historical data through the first quarter of CY 2026 and forecasted data for the second quarter of CY 2026 through the third quarter of CY 2027.

The forecast error has been both positive and negative during past years, and over longer periods of time the cumulative forecast has not deviated significantly from the historical measures. Only considering the forecast error for years when the IRF market basket update was lower than the actual market basket update would not fully account for forecast error.

After consideration of the public comments received, we are finalizing a FY 2027 IRF productivity-adjusted market basket increase of 2.3 percent based on the most recent data available. This reflects a 3.2 percent market basket percentage increase, less the 0.9 percentage point productivity adjustment required by law.

C. FY 2027 IRF Labor-Related Share

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act, for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We proposed to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2021-based IRF market basket, we proposed to calculate the labor-related share for FY 2027 as the sum of the FY 2027 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related relative importance from the 2021-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2021-based IRF labor-related share, see the FY 2024 IRF PPS final rule (88 FR 50985 through 50988).

The relative importance reflects the different rates of price change for these cost categories between the base year (2021) and FY 2027. We calculate the labor-related relative importance from the IRF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2027. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Based on IGI's fourth quarter 2025 forecast of the 2021-based IRF market basket, the sum of the FY 2027 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services was 70.8 percent. We proposed that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs was 8.1 percent of the 2021-based IRF market basket for FY 2027, we proposed to take 46 percent of 8.1 percent to determine the labor-related share of Capital-Related costs for FY 2027 which is 3.7 percent. Therefore, we proposed a total labor-related share for FY 2027 of 74.5 percent (the sum of 70.8 percent for the proposed labor-related share of operating costs and 3.7 percent for the proposed labor-related share of Capital-Related costs). We also proposed that if more recent data subsequently became available after publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the labor-related share), we would use such data, if appropriate, to determine the FY 2027 IRF labor-related share in this final rule.

Based on IGI's second quarter 2026 forecast for the 2021-based IRF market basket, the sum of the FY 2027 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 70.6 percent. The portion of Capital-Related costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2016-based IRF market basket (84 FR 39088 and 39089). Since the relative importance for Capital is 8.1 percent of the 2021-based IRF market basket in FY 2027, we took 46 percent of 8.1 percent to determine the labor-related share of Capital-Related costs for FY 2027 of 3.7 percent. Therefore, the total labor-related share for FY 2027 based on more recent data is 74.3 percent (the sum of 70.6 percent for the operating costs and 3.7 percent).

We invited public comments on the proposed labor-related share for FY 2027. The following is a summary of the public comments received and our responses.

Comment: A commenter appreciated CMS' continued evaluation of the labor-related share and encouraged CMS to consider the disproportionate impact of escalating workforce costs, including recruitment and retention challenges, on IRFs. Another commenter encouraged CMS to continue refining the labor-related share calculation as more recent base-year data become available and in particular to reflect the growing role of contract and agency labor that has become structurally embedded in IRF operations since the pandemic.

Response: We proposed to use the FY 2027 relative importance values for the labor-related cost categories from the 2021-based IRF market basket because it accounts for more recent data regarding price pressures and cost structure of IRFs. This methodology is consistent with the determination of the labor-related share since the implementation of the IRF PPS. As stated in the FY 2027 IRF proposed rule, we also proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2027 labor-related share for the final rule. Based on IGI's second quarter 2026 forecast with historical data through the first quarter of 2026, the FY 2027 labor-related share for the final rule is 74.3 percent, reflecting expectations of a slight softening of the labor market cost

pressures since the proposed rule forecast. We note the FY 2027 labor-related share is slightly lower than the FY 2026 labor-related share. After consideration of the public comments received, we are finalizing a FY 2027 labor-related share of 74.3 percent.

Table 4 shows the estimate of the FY 2027 labor-related share and the FY 2026 final labor-related share using the 2021-based IRF market basket relative importance.

TABLE 4: FY 2027 IRF Labor-Related Share and FY 2026 IRF Labor-Related Share

	FY 2027 Final Labor-Related Share[1]	FY 2026 Final Labor-Related Share[2]
Wages and Salaries	49.3	49.4
Employee Benefits	11.8	11.8
Professional Fees: Labor-Related[3]	5.5	5.5
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance, and Repair Services	1.5	1.5
All Other: Labor-Related Services	1.8	1.8
Subtotal	**70.6**	**70.7**
Labor-related portion of Capital-Related (46%)	3.7	3.7
Total Labor-Related Share	**74.3**	**74.4**

[1] Based on the 2nd quarter 2026 IHS Global Inc. forecast of the 2021-based IRF market basket.

[2] Published in the **Federal Register** (90 FR 37692); based on 2nd quarter 2025 IHS Global Inc. forecast of the 2021-based IRF market basket.

[3] Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office contract labor costs.

D. Wage Adjustment for FY 2027

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustments or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

In the FY 2023 IRF PPS final rule (87 FR 47054 through 47056), we finalized a policy to apply a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. We amended IRF PPS regulations at § 412.624(e)(1)(ii) to reflect this permanent cap on wage index decreases. Additionally, we finalized a policy that a new IRF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IRF would not have a wage index in the prior FY. A full discussion of the adoption of this policy is found in the FY 2023 IRF PPS final rule.

For FY 2027, we proposed to maintain the policies and methodologies described in the FY 2026 IRF PPS final rule (90 FR 37678) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we use the core based statistical areas (CBSAs) labor market area definitions and the FY 2027 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2027 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2022, and before October 1, 2023 (that is, FY 2024 cost report data).

In addition, we will continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2027 IRF PPS wage index. For FY 2027, the only rural area without wage index data available is in North Dakota. For urban areas without specific hospital wage index data, we will continue using the average wage indexes of all urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA as established in FY 2006 (70 FR 47927). For FY 2027, the only urban area without wage index data available is CBSA 25980, Hinesville Fort Stewart, Georgia.

For FY 2027, we proposed to continue to use the concurrent pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) hospital wage index as the basis for the IRF wage index. We continue to consider this an appropriate source of wage index data to estimate costs per day, consistent with our wage index policy at § 412.624(e)(1).

We routinely assess whether more recent or alternative data sources may further enhance the accuracy and representativeness of our estimates. We note that other payment systems have explored and are exploring alternative wage index methodologies under their specific programmatic and statutory circumstances. For example, CMS finalized changes to the End-Stage Renal Disease (ESRD) PPS wage index using the Bureau of Labor Statistics (BLS) occupation-level wage data in the CY 2025 ESRD PPS final rule (89 FR 89084). While this approach was developed under the specific programmatic and statutory circumstances of the ESRD PPS and may not be directly transferable to the IRF PPS, CMS is interested in exploring whether similar methodologies using publicly available wage data could be adapted to reflect the geographic variation in labor costs for inpatient rehabilitation facilities.

In its 2023 Report to Congress,[4] MedPAC discussed various conceptual approaches to Medicare wage indexes, including the use of county-level wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting. MedPAC has previously written about using all-employer, occupation-level wage data to establish different weights for setting-specific occupational labor mixes as one approach to geographic adjustments.

We solicited comments on whether we should consider using alternative data sources to construct an IRF-specific wage index for potential use in future years. CMS sought feedback to understand the potential advantages and limitations of using alternative data sources, such as BLS data and IRF cost reports, as well as other methodologies that interested parties believe could appropriately reflect the geographic variation in labor costs for IRFs. In addition, as discussed elsewhere in the **Federal Register**, we note that we are also considering the potential use of alternative data sources in other payment systems including the Inpatient Facilities PPS, Skilled Nursing Facilities PPS, and Hospice PPS. We sought feedback on the unique considerations applicable to IRFs that should inform how CMS considers the potential use of alternative data sources.

We invited public comments on our proposals regarding the Wage Adjustment for FY 2027 and on the potential use of alternative data sources for the IRF PPS Wage index. The following is a summary of the public comments received and our responses.

Comment: Most commenters supported CMS' proposal to maintain the current IRF wage index methodology for FY 2027. Many commenters raised concerns about aspects of the current methodology, particularly CMS' use of the pre-reclassification, pre-floor IPPS wage index. These commenters stated that because IRFs compete with hospitals for the same clinical workforce, they should benefit from the same wage index adjustments available under IPPS, including geographic reclassifications, rural floor policies, and out-migration adjustments. Commenters contended that relying on pre-reclassification and pre-floor wage index values understates actual labor costs for many IRFs and places them at a competitive disadvantage when recruiting and retaining staff. Commenters encouraged CMS to continue evaluating reforms that would promote greater parity across provider types and better align IRF payments with local labor market conditions while maintaining payment stability. While there was general support for finalizing the proposed FY 2027 methodology, comments reflected ongoing concerns about whether the current implementation fully captures labor costs faced by IRFs in certain markets.

Response: We appreciate the commenters' suggestion to adopt the IPPS post-classification and post-floor hospital IPPS wage index and other IPPS wage index adjustments for the IRF wage index. We also acknowledge and appreciate the commenters' concerns regarding competition for labor resulting from different applicable wage index policies across different settings of care.

As most recently discussed in the FY 2026 IRF PPS final rule and correction notice (90 FR 37678 [5] and 90 FR 58509,[6] respectively), the IRF wage index is derived from IPPS wage data, that is, the pre-reclassification and pre-floor IPPS wage index discussed in this final rule. We note that IPPS wage index values are based on historical data and typically lag by 4 years. Thus, to the extent that increasing wage index values under the IPPS for low wage index hospitals results in those hospitals increasing employee compensation, this increase would be reflected in the IPPS wage data that the IRF wage index is derived from and likely would result in higher wage indices for these areas under the IRF PPS. As such, any effects of this policy on the wage data of IPPS hospitals would be extended to the IRF setting, as this data would be used to establish the wage index for IRFs in the future.

We may take all of these concerns into consideration during future work on a potential payment system-specific wage index.

Comment: In response to our request for information on alternative data sources for the IRF PPS wage index calculation, commenters urge CMS to proceed cautiously before implementing any IRF-specific wage index. Commenters emphasized that any future methodology should be transparent, data-driven, administratively feasible, and developed with extensive interested party engagement. Although some believed implementation of an IRF-specific wage index could eventually be beneficial if developed carefully, the commenters cautioned against making significant methodological changes without sufficient analysis and provider engagement.

Many commenters stated that the existing IPPS-based wage index remains the most appropriate proxy because IRFs compete with acute care hospitals for the same labor pool and face similar wage pressures. These commenters stated that developing an IRF-specific wage index would be challenging due to limitations in available data, particularly because IRF-specific wage information is often embedded within broader hospital cost reports and because most IRFs are hospital-based units whose labor costs cannot be easily separated from those of their parent hospitals. These commenters recommended updates to the current methodology, such as applying the 5 percent cap on a non-budget-neutral basis and aligning wage index policies like geographic reclassification and low-wage index floors between IRFs and IPPS to increase parity with IPPS hospitals. In making updates to the wage index methodology, commenters expressed caution and recommended that any future changes be phased in gradually, remain budget neutral, retain protections such as the 5 percent cap on annual wage index decreases, and be accompanied by extensive interested party engagement (for example, Technical Evaluation Panels), modeling, and impact analyses.

Commenters who supported the development of an IRF specific wage index stated that a wage index calculated by using Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) data would improve the accuracy of geographic labor costs that IRFs incur. They remarked that this data is publicly available and would reduce administrative burden compared to cost report data. MedPAC noted CMS could also consider modifying the current cost reports to include sector-specific occupation weights through BLS data or an episodic occupational mix survey (like IPPS hospitals). Additionally, MedPAC suggested that CMS also consider in their wage index updates MedPAC's prior suggestions of using additional data (for example, the Census Bureau's American Community Survey) to improve wage accuracy in metropolitan statistical areas and to smooth wage index differences across adjacent areas. Other commenters in favor of an IRF specific wage index also suggested that CMS consider combining multiple data sources, including BLS

[4] *https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system, https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf.*

[5] *https://www.federalregister.gov/documents/2025/08/05/2025-14780/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal.*

[6] *https://www.govinfo.gov/app/details/FR-2025-12-17/2025-23081.*

data, cost reports, occupational mix information, and geographic labor market adjustments, rather than relying on a single source. Many commenters expressed concerns about using BLS wage data as the primary basis for an IRF-specific wage index. Commenters stated that BLS data are not setting-specific, include employers outside the hospital sector, exclude employee benefits and other components of total compensation, may not adequately capture contract labor costs, and are based on surveys that are less transparent and auditable than Medicare cost reports. Many commenters also stated that BLS occupational categories may not accurately reflect the unique staffing mix of IRFs, including rehabilitation nurses, therapists, and other specialized personnel. Several commenters emphasized that providers currently have opportunities to review and correct Medicare cost report data used in wage index calculations, whereas BLS confidentiality rules would limit validation of the underlying data. Even among those open to reform, commenters generally expressed that CMS should develop and publicly test any new methodology before implementation, provide detailed impact analyses, and phase in significant changes over multiple years to avoid payment disruptions.

Response: We greatly appreciate commenters' thoughtful comments and suggestions for the use of alternative data from cost reports or BLS to calculate an IRF PPS wage index, modifying the existing methodology, and anticipated limitations of a setting-specific wage index. We may take these into consideration if CMS develops an IRF specific wage index. After consideration of the comments we received, we are finalizing the updates to the wage index as proposed for FY 2027.

2. Core-Based Statistical Areas (CBSAs) for the FY 2027 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor hospital wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010, **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our use of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years based on the results of the decennial census. Additionally, OMB occasionally issues updates and revisions to the statistical areas in between decennial censuses to reflect the recognition of new areas or the addition of counties to existing areas. In some instances, these updates merge formerly separate areas, transfer components of an area from one area to another or drop components from an area. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012, and July 1, 2013.

In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 IRF wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule. In the FY 2019 IRF PPS final rule (83 FR 38527), we continued to use the OMB delineations that were adopted beginning with FY 2016 to calculate the area wage indexes, with updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

On August 15, 2017, OMB issued OMB Bulletin No. 17–01, which provided updates to and superseded OMB Bulletin No. 15–01 that was issued on July 15, 2015. The attachments to OMB Bulletin No. 17–01 provide detailed information on the update to statistical areas since July 15, 2015, and are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2014, and July 1, 2015. In the FY 2020 IRF PPS final rule (84 FR 39090 through 39091), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IRF wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03, which superseded the August 15, 2017 OMB Bulletin No. 17–01, and on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.*

To this end, as discussed in the FY 2021 IRF PPS proposed (85 FR 22075 through 22079) and final (85 FR 48434 through 48440) rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1 year transition for FY 2021 under which we applied a 5-percent cap on any decrease in an IRF's wage index compared to its wage index for the prior fiscal year (FY 2020). The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the IRF PPS. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, we did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 through FY 2024.

On July 21, 2023, OMB issued OMB Bulletin No. 23–01 (available at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf*) which updates and supersedes OMB Bulletin No. 20–01 based upon the 2020 Standards for Delineating Core Based Statistical Areas (''the 2020 Standards'') published by OMB on July 16, 2021 (86 FR 37770). OMB Bulletin No. 23–01 revised CBSA delineations that are comprised of counties and

equivalent entities (for example, boroughs; a city and borough; and a municipality in Alaska; planning regions in Connecticut; parishes in Louisiana; municipios in Puerto Rico; and independent cities in Maryland, Missouri, Nevada, and Virginia). As discussed in the FY 2025 IRF PPS final rule (89 FR 64291 through 64304), we adopted the revised OMB delineations identified in OMB Bulletin No. 23–01.

3. Final Year of the 3-Year Phase Out of the Rural Adjustment

For FY 2027, CMS is continuing the 3-year budget-neutral phase-out of the rural adjustment for FY 2024 IRFs transitioning from rural to urban status in FY 2025 under the revised CBSA delineations. Consistent with the transition policy adopted in the FY 2006 IRF final rule (70 FR 47923 [7] through 47927 [8]), we finalized in the FY 2025 IRF PPS final rule (89 FR 64276) a budget neutral 3-year phase-out of the rural adjustment for existing FY 2024 rural IRFs that became urban in FY 2025. The purpose of this gradual phase-out of the rural adjustment for these facilities was to reduce the potential negative financial impacts associated with this reclassification. We refer readers to the FY 2025 IRF final rule for additional discussion of this policy (89 FR 64302 through 64304). In FY 2027, the final year of this phase-out, affected IRFs will receive the full FY 2027 wage index with no further FY 2024 rural adjustment. Furthermore, this policy does not apply to urban IRFs transitioning to rural status, as they will receive the full rural adjustment.

The following is a summary of the public comments received and our responses to the proposal regarding the final year of the 3-year phase out of the rural adjustment.

Comment: Comments were supportive of CMS' proposal to complete the final year of the rural-to-urban adjustment phase-out as previously adopted. Commenters stated that the phased reduction helps facilities adjust gradually, maintain financial and operational stability, and protect staffing and access to rehabilitation services, particularly in communities that may still rely on these providers despite reclassification. However, commenters also encouraged CMS to continue monitoring the policy's effects on provider financial stability and access to rehabilitation care, particularly for rural communities that may be vulnerable to reductions in reimbursement.

Response: We appreciate the commenters' feedback on the continued phase-out policy for IRFs that were redesignated from rural to urban CBSAs. We believe the 3-year phase-out of the rural adjustment provides a sufficient transition for IRFs previously designated in rural CBSAs that received the rural adjustment. However, we will continue to monitor future CBSA delineation updates to assess whether CBSA delineation changes disproportionately impact certain provider populations, such as low-income patients.

After consideration of the comments we received, we are finalizing the final year of the 3-year budget-neutral phase-out of the rural adjustment for FY 2024 IRFs transitioning from rural to urban status in FY 2027 under the revised CBSA delineations as proposed.

4. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the payment rates set forth in this final rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2027 labor-related share based on the 2021-based IRF market basket relative importance (74.3 percent) to determine the labor-related portion of the standard payment amount. (A full discussion of the calculation of the labor-related share appears in section VI.C. of this final rule). We then multiply the labor-related portion by the applicable IRF wage index. The wage index tables are available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files.*

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689) and codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2027 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2023 hospital cost report data) and the update to the labor-related share, in a budget-neutral manner:

Step 1. Calculate the total amount of estimated IRF PPS payments using the labor-related share and the wage indexes from FY 2026 (as published in the FY 2026 IRF PPS final rule (90 FR 37678)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2027 wage index values (based on updated hospital wage data and taking into account the permanent 5-percent cap on wage index decreases when applicable) and the FY 2027 labor-related share of 74.3 percent.

Step 3. Divide the amount calculated in Step 1 by the amount calculated in Step 2. The resulting quotient is the FY 2027 budget-neutral wage adjustment factor of 1.0036.

Step 4. Apply the budget neutrality factor from Step 3 to the FY 2027 IRF PPS standard payment amount after the application of the market basket percentage increase to determine the FY 2027 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2027 in section VI.E. of this final rule.

We invited public comments on our proposals regarding the wage adjustment for FY 2027. The following is a summary of the public comments received and our responses.

Comment: Many commenters expressed support for retaining current wage index policies, particularly the permanent 5-percent cap on wage index decreases. However, some expressed that CMS should apply that cap on a non-budget-neutral basis.

Response: We appreciate the commenters' support of the permanent cap on wage index decreases. We realize that the 5-percent cap on annual decreases in the wage index values does not eliminate the effects of annual changes in the wage index, but we believe that it does substantially reduce the financial impact on IRFs of these annual changes. The wage index tables for IRF PPS are provided at the CBSA level. The 5-percent cap policy is applied at the provider level. Hence, when the 5-percent cap is applicable, each IRF should work directly with its Medicare Administrative Contractor (MAC) to understand how the 5-percent cap is applied. MACs have more detailed information about the location of each IRF and the applicability of the 5-percent cap to each IRFs situation, and CMS has provided instructions to the MACs on applying the 5-percent cap policy (see publication 100–04 Medicare Claims Processing Manual, Chapter 3).

Adjustments for geographic variations in labor costs for a FY will continue to be made in a budget-neutral manner as required by the statute at section 1886(j)(6) of the Act. We refer readers to the FY 2023 IRF PPS final rule (87 FR

[7] *https://www.federalregister.gov/citation/70-FR-47923.*

[8] *https://www.federalregister.gov/citation/70-FR-47927.*

47054 [9] through 47056 [10]) for a detailed discussion on the wage index cap policy.

We did not receive any comments on the proposed budget-neutral wage adjustment factor methodology, and therefore, we are finalizing as proposed.

E. Description of the IRF Standard Payment Conversion Factor Methodology and Payment Rates for FY 2027

To calculate the IRF standard payment conversion factor for FY 2027, as illustrated in Table 5, we begin by applying the IRF market basket update for FY 2027, as adjusted in accordance with sections 1886(j)(3)(C) of the Act, to the standard payment conversion factor for FY 2026 ($19,371). Applying the 2.3 percent IRF market basket update for FY 2027 to the standard payment conversion factor for FY 2026 of $19,371 yields a FY 2027 standard payment amount of $19,817. Then, we apply the budget neutrality factor for the FY 2027 wage index (taking into account the policy placing a permanent 5-percent cap on decreases to a provider's wage index), and labor-related share of 1.0036, which results in an IRF standard payment amount of $19,888. We next apply the budget neutrality factor for the CMG relative weights of 0.9990, which results in the IRF standard payment conversion factor of $19,868 for FY 2027.

TABLE 5: Calculations to Determine the FY 2027 IRF Standard Payment Conversion Factor

Explanation for Adjustment	Calculations	
FY 2026 IRF Standard Payment Conversion Factor		$19,371
Market Basket Update for FY 2027 of 2.3 percent*	x	1.0230
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x	1.0036
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9990
FY 2027 Standard Payment Conversion Factor	= $19,868	

*Reflects a FY 2027 3.2 percent IRF market basket percentage increase reduced by 0.9 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We then apply the CMG relative weights described in section V.E of this final rule to the FY 2027 standard payment conversion factor ($19,868), to determine the unadjusted IRF prospective payment rates for FY 2027. The unadjusted IRF prospective payment rates for FY 2027 are shown in Table 6.

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[9] *https://www.federalregister.gov/documents/2022/08/01/2022-16225/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal#page-47054.*

[10] *https://www.federalregister.gov/documents/2022/08/01/2022-16225/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal#page-47056.*

TABLE 6: FY 2027 IRF PPS Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 19,550.11	$ 16,776.54	$ 15,308.29	$ 14,682.45
0102	$ 24,916.46	$ 21,379.95	$ 19,510.38	$ 18,711.68
0103	$ 31,923.90	$ 27,394.00	$ 24,997.92	$ 23,974.72
0104	$ 40,415.49	$ 34,681.58	$ 31,647.74	$ 30,352.34
0105	$ 51,436.27	$ 44,138.75	$ 40,276.41	$ 38,629.35
0106	$ 58,705.97	$ 50,377.30	$ 45,968.59	$ 44,087.09
0201	$ 22,182.62	$ 17,499.73	$ 16,057.32	$ 15,057.96
0202	$ 27,413.87	$ 21,626.32	$ 19,844.16	$ 18,608.37
0203	$ 34,415.35	$ 27,147.64	$ 24,912.49	$ 23,360.79
0204	$ 42,573.15	$ 33,582.88	$ 30,817.25	$ 28,898.01
0205	$ 55,072.11	$ 43,441.38	$ 39,865.14	$ 37,381.64
0301	$ 24,384.00	$ 18,701.75	$ 17,565.30	$ 16,248.05
0302	$ 31,367.60	$ 24,058.16	$ 22,595.88	$ 20,903.12
0303	$ 38,084.97	$ 29,209.93	$ 27,433.73	$ 25,379.38
0304	$ 44,695.05	$ 34,280.25	$ 32,196.09	$ 29,784.12
0305	$ 48,493.81	$ 37,192.90	$ 34,931.92	$ 32,315.30
0401	$ 25,945.62	$ 22,423.02	$ 20,948.82	$ 19,099.11
0402	$ 32,343.12	$ 27,954.28	$ 26,114.50	$ 23,809.81
0403	$ 41,013.51	$ 35,446.50	$ 33,114.00	$ 30,191.41
0404	$ 62,147.10	$ 53,713.14	$ 50,178.62	$ 45,750.04
0405	$ 50,885.92	$ 43,979.80	$ 41,085.04	$ 37,459.13
0406	$ 63,724.62	$ 55,078.07	$ 51,452.16	$ 46,910.33
0407	$ 89,175.53	$ 77,073.93	$ 72,001.63	$ 65,645.86
0501	$ 25,192.62	$ 19,935.55	$ 18,751.42	$ 17,456.02
0502	$ 30,916.59	$ 24,465.46	$ 23,011.12	$ 21,423.66
0503	$ 34,872.31	$ 27,596.65	$ 25,955.56	$ 24,163.46
0504	$ 41,953.27	$ 33,199.43	$ 31,226.54	$ 29,070.86
0505	$ 58,735.77	$ 46,483.17	$ 43,719.53	$ 40,701.58
0601	$ 27,159.56	$ 19,885.88	$ 18,516.98	$ 16,981.18
0602	$ 33,799.44	$ 24,747.58	$ 23,042.91	$ 21,131.60
0603	$ 39,662.49	$ 29,041.06	$ 27,040.35	$ 24,797.25
0604	$ 50,013.72	$ 36,620.70	$ 34,097.46	$ 31,268.26
0701	$ 24,858.84	$ 19,194.47	$ 18,008.36	$ 16,689.12
0702	$ 30,878.85	$ 23,841.60	$ 22,367.39	$ 20,730.27
0703	$ 38,388.95	$ 29,641.07	$ 27,809.24	$ 25,772.77
0704	$ 47,399.09	$ 36,596.86	$ 34,335.88	$ 31,820.59
0801	$ 23,867.43	$ 19,178.58	$ 17,573.25	$ 16,693.09
0802	$ 27,111.87	$ 21,785.26	$ 19,961.38	$ 18,960.03
0803	$ 29,933.13	$ 24,052.20	$ 22,039.57	$ 20,932.92
0804	$ 34,071.63	$ 27,378.10	$ 25,087.32	$ 23,827.69
0805	$ 41,804.26	$ 33,590.83	$ 30,779.51	$ 29,235.76
0901	$ 23,942.93	$ 18,604.40	$ 17,563.31	$ 16,275.87

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0902	$ 30,419.89	$ 23,638.95	$ 22,315.74	$ 20,678.61
0903	$ 35,897.50	$ 27,894.67	$ 26,333.05	$ 24,401.88
0904	$ 43,681.78	$ 33,944.48	$ 32,045.10	$ 29,692.73
1001	$ 24,085.98	$ 20,376.62	$ 18,218.96	$ 16,552.03
1002	$ 29,712.59	$ 25,135.01	$ 22,474.68	$ 20,418.34
1003	$ 36,257.11	$ 30,672.22	$ 27,425.79	$ 24,914.47
1004	$ 46,332.18	$ 39,193.60	$ 35,047.15	$ 31,838.47
1101	$ 24,326.38	$ 20,847.49	$ 20,042.84	$ 17,823.58
1102	$ 31,212.63	$ 26,748.29	$ 25,715.15	$ 22,868.07
1103	$ 38,683.00	$ 33,149.76	$ 31,870.26	$ 28,341.70
1201	$ 22,655.48	$ 19,538.19	$ 17,754.04	$ 16,649.38
1202	$ 28,186.73	$ 24,308.50	$ 22,089.24	$ 20,714.38
1203	$ 37,649.86	$ 32,470.27	$ 29,505.97	$ 27,668.18
1204	$ 37,401.51	$ 32,255.70	$ 29,311.26	$ 27,485.39
1301	$ 23,724.38	$ 18,224.92	$ 18,038.16	$ 16,454.68
1302	$ 31,331.84	$ 24,068.10	$ 23,821.73	$ 21,731.62
1303	$ 36,219.36	$ 27,823.15	$ 27,537.05	$ 25,121.10
1304	$ 45,289.11	$ 34,788.87	$ 34,433.23	$ 31,411.31
1305	$ 42,942.70	$ 32,986.84	$ 32,649.08	$ 29,784.12
1401	$ 22,339.58	$ 17,946.76	$ 16,381.17	$ 15,012.26
1402	$ 28,405.28	$ 22,818.40	$ 20,829.61	$ 19,087.19
1403	$ 34,594.16	$ 27,791.36	$ 25,369.45	$ 23,247.55
1404	$ 42,177.78	$ 33,882.89	$ 30,930.50	$ 28,343.69
1501	$ 26,418.48	$ 20,875.31	$ 19,746.81	$ 18,616.32
1502	$ 32,919.29	$ 26,013.17	$ 24,604.53	$ 23,197.88
1503	$ 37,693.57	$ 29,784.12	$ 28,172.82	$ 26,561.53
1504	$ 46,592.45	$ 36,817.39	$ 34,824.63	$ 32,831.87
1601	$ 23,034.96	$ 17,607.02	$ 15,997.71	$ 14,656.62
1602	$ 27,759.57	$ 21,221.01	$ 19,279.91	$ 17,664.64
1603	$ 35,976.97	$ 27,501.29	$ 24,986.00	$ 22,891.91
1604	$ 46,340.12	$ 35,424.64	$ 32,184.17	$ 29,486.10
1701	$ 28,105.27	$ 20,591.20	$ 19,073.28	$ 17,714.31
1702	$ 34,828.60	$ 25,518.46	$ 23,634.97	$ 21,952.15
1703	$ 40,641.98	$ 29,778.16	$ 27,580.76	$ 25,615.81
1704	$ 46,465.29	$ 34,043.82	$ 31,532.50	$ 29,285.43
1705	$ 55,366.16	$ 40,564.50	$ 37,572.37	$ 34,896.16
1801	$ 22,836.28	$ 18,222.93	$ 16,945.42	$ 15,632.14
1802	$ 28,784.76	$ 22,969.39	$ 21,358.10	$ 19,705.08
1803	$ 36,459.77	$ 29,094.70	$ 27,054.26	$ 24,958.18
1804	$ 41,146.63	$ 32,833.86	$ 30,531.16	$ 28,166.86
1805	$ 49,793.18	$ 39,734.01	$ 36,948.52	$ 34,085.54
1806	$ 70,626.77	$ 56,357.57	$ 52,407.81	$ 48,346.79
1901	$ 21,324.32	$ 18,932.22	$ 16,865.95	$ 16,422.89
1902	$ 31,158.98	$ 27,664.20	$ 24,644.27	$ 23,996.57

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1903	$ 44,490.41	$ 39,499.57	$ 35,188.21	$ 34,262.37
1904	$ 67,529.35	$ 59,955.66	$ 53,411.14	$ 52,004.49
2001	$ 23,998.56	$ 18,868.64	$ 17,354.70	$ 16,116.92
2002	$ 29,724.51	$ 23,370.73	$ 21,495.19	$ 19,963.37
2003	$ 35,243.85	$ 27,709.90	$ 25,486.67	$ 23,668.75
2004	$ 42,481.76	$ 33,400.09	$ 30,719.90	$ 28,530.45
2005	$ 45,223.54	$ 35,553.79	$ 32,702.73	$ 30,370.22
2101	$ 32,251.72	$ 25,953.57	$ 24,366.12	$ 20,758.09
2102	$ 48,823.62	$ 39,290.96	$ 36,886.93	$ 31,425.22
5001	$ -	$ -	$ -	$ 3,494.78
5101	$ -	$ -	$ -	$ 17,191.78
5102	$ -	$ -	$ -	$ 38,730.68
5103	$ -	$ -	$ -	$ 18,904.40
5104	$ -	$ -	$ -	$ 45,122.21

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F. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 7 illustrates the methodology for adjusting the prospective payments (as described in section V. of this final rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified as CMG 0104 (without comorbidities). The unadjusted prospective payment rate for CMG 0104 (without comorbidities) appears in Table 6.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8604, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454), a wage index of 0.9326, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the prospective payment, we begin by taking the FY 2027 unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 6. Then, we multiply the labor-related share for FY 2027 (74.3 percent) described in section VI. of this final rule by the unadjusted prospective payment rate. To determine the non-labor portion of the prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted prospective payment.

To compute the wage-adjusted prospective payment, we multiply the labor portion of the Federal payment by the appropriate wage index located in the applicable wage index table. This table is available on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/rules-related-files.*

The resulting figure is the wage-adjusted labor amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the Federal payment.

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 7 illustrates the components of the adjusted payment calculation.

TABLE 7: Example of Computing the FY 2027 IRF Prospective Payment Rate

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		$ 30,352.34		$ 30,352.34
2	Labor-Related Share	X	0.743	X	0.743
3	Labor Portion of Payment	=	$22,551.79	=	$22,551.79
4	CBSA-Based Wage Index	X	0.8604	X	0.9326
5	Wage-Adjusted Amount	=	$19,403.56	=	$21,031.80
6	Non-Labor Amount	+	$ 7,800.55	+	$ 7,800.55
7	Wage-Adjusted Payment	=	$ 27,204.11	=	$ 28,832.35
8	Rural Adjustment	X	1.149	X	1.000
9	Wage- and Rural-Adjusted Payment	=	$31,257.52	=	$28,832.35
10	LIP Adjustment	X	1.0156	X	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	$31,745.14	=	$30,141.34
12	Wage- and Rural-Adjusted Payment		$31,257.52		$28,832.35
13	Teaching Status Adjustment	X	0	X	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,260.46
15	Wage-, Rural-, and LIP-Adjusted Payment	+	$31,745.14	+	$30,141.34
16	Total Adjusted Payment	=	$31,745.14	=	$32,401.79

Thus, the adjusted payment for Facility A would be $31,745.14 and the adjusted payment for Facility B would be $32,401.79.

VII. Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2027

A. Update to the Outlier Threshold Amount for FY 2027

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall Cost-to-Charge Ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the FY 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high- cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2026 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, 82 FR 36238, 83 FR 38514, 84 FR 39054, 85 FR 48444, 86 FR 42362, 87 FR 47038, 88 FR 50956, 89 FR 64276 and 90 FR 37678, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 through 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2027, we proposed to use FY 2025 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2026. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2027, we estimated the amount of FY 2027 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2025) and the FY 2027 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-neutrality adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an

analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 2.6 percent in FY 2026. Therefore, we proposed to update the outlier threshold amount from $10,141 for FY 2026 to $8,689 for FY 2027 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2027.

We note that, with our longstanding practice when developing previous IRF PPS fiscal year rules, we update our data between the FY 2027 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments.

We invited public comments on the proposed update to the IRF outlier threshold for FY 2027. The following is a summary of the public comments received and our responses.

Comment: Commenters were broadly supportive of CMS' proposal to reduce the IRF high-cost outlier threshold to maintain a target of 3 percent of total payments. However, they also discussed ongoing challenges related to patient complexity, labor costs, and operating expenses and suggested CMS continue monitoring the outlier methodology to ensure payments remain adequate for the most complex and costly IRF cases. Commenters also expressed a desire for increased transparency regarding the outlier threshold calculation methodology.

Although many commenters acknowledged and affirmed the current outlier payment policy's role in compensating IRFs for high-cost patients, others opined that the high-cost outlier payment policy should provider even greater compensation. According to some commenters, options for this include further lowering the outlier threshold (either in FY 2027 or future years), carving out special payments for high-cost conditions not explicitly accounted for by the CMG system (for example, cancer or transplant recovery), and/or increasing the share of estimated costs covered by outlier payments.

Several commenters expressed concern over the uneven distribution of outlier payments across providers and shared some potential solutions. Two potential solutions sought to impose limits on the amount of outlier payments IRFs could receive by: (1) capping outlier payments at 10 percent of IRFs' PPS revenue, and (2) reducing the outlier pool to less than 3 percent of total payments. Other solutions sought to reduce the influence of atypical IRFs on the final threshold calculation by incorporating outlier reconciliation dollars into payment projections and/or dropping IRFs that have costs exceeding three standard deviations (SDs) from the mean when calculating the outlier threshold. Lastly, some commenters recommended that CMS conduct a detailed analysis of the drivers of fluctuations and concentrations of payments across IRFs.

Multiple commenters also expressed concern over the year-to-year volatility of the outlier threshold and recommended that CMS adopt a multi-year averaging approach as a remedy. Commenters suggest that smoothing the volatility would help them budget more accurately for future years. Commenters also requested that CMS allow individual IRFs to work with MACs to obtain hospital-specific CCRs.

Response: We thank the commenters for their support for the outlier threshold update. We continue to believe that maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs caring for the highest-cost patients, while still providing for adequate payments for all other non-outlier cases. We continue to monitor our approach to ensure that IRFs who treat medically complex patients are adequately reimbursed.

We acknowledge the suggestion to modify the outlier threshold methodology to use a multi-year average; however, it has been our long-standing practice to utilize the most recent full fiscal year of data to update the prospective payment rates and determine the outlier threshold amount, as this data is generally considered to be the best overall predictor of experience in the upcoming fiscal year. Any future consideration given to imposing a limit on outlier payments or adjusting the outlier threshold to account for historical outlier reconciliation dollars would need to be carefully assessed and take into consideration the effect on access to IRF care for certain high-cost populations. We will continue to examine ways of enhancing the stability and predictability of the outlier threshold from year-to-year.

After considering the comments received and applying the most recent available data, we are finalizing the outlier threshold amount of $8,857 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2027.

B. Update to the IRF Cost-to-Charge Ratio (CCR) Ceiling and Urban/Rural Averages for FY 2027

CCRs are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from Medicare Cost Reports (MCRs). IRF-specific CCRs are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF PPS. In accordance with the methodology described in the FY 2004 IRF PPS final rule (68 FR 45692 through 45694), we proposed to apply a ceiling to IRFs' CCRs. Using that methodology, we proposed to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2027, based on analysis of the most recent data available. We apply the national urban and rural CCRs to:

- New IRFs that have not yet submitted their first MCR.
- IRFs with an overall CCR that exceeds the national CCR ceiling for FY 2027, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2027, we proposed to estimate a national average CCR of 0.461 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we proposed to estimate a national average CCR of 0.386 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We applied weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For the proposed rule, we used the most recent available cost report data (FY 2024). This includes all IRFs whose cost reporting periods begin on or after October 1, 2023, and before October 1, 2024. If, for any IRF, the FY 2024 cost report was missing or had an ''as submitted'' status, we used the most recent FY for which a settled cost report was available (that is, from a FY between FY 2004 and FY 2024) for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care. Using updated FY 2024 cost report data for this final rule, we estimate a national average CCR of 0.465 for rural IRFs and

a national average CCR of 0.386 for urban IRFs.

In accordance with past practice, we proposed to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.56 for FY 2027. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.56 for FY 2027, we will replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in Step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in Step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from Step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from Step 1.

We also proposed that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, we would use such data to determine the FY 2027 national average rural and urban CCRs and the national CCR ceiling in the final rule. Using the FY 2024 cost report data for this final rule, we estimate a national average CCR ceiling of 1.56, using the same methodology.

We invited public comments on the proposed update to the IRF CCR ceiling and urban/rural averages for FY 2027. The following is a summary of the public comments received and our responses.

We did not receive any comments on the proposed updates to the FY 2027 IRF CCR ceiling and urban/rural averages; therefore, we are finalizing the CCR ceiling and urban/rural averages based on updated data for FY 2027.

VIII. Proposals To Revise the Basis of Payment Requirements

A. Initiation of Therapies No Later Than 36-Hours From Admission

In accordance with 42 CFR 412.622(a)(3)(ii), for an IRF claim to be considered reasonable and necessary, the patient's intensive rehabilitation therapy program must consist of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. Under certain well-documented cases when a patient is unable to receive 3 hours of therapy daily, such as during reduced therapy tolerance at the beginning of a patient's IRF stay or the occurrence of a medical procedure that interferes with the provision of therapy, this program might consist of at least 15 hours of intensive rehabilitation therapy provided per week. As discussed in the FY 2010 IRF PPS final rule, the 36-hour requirement was established to require IRFs to initiate rehabilitation therapies as soon as possible after admission to the IRF to ensure that patients are able to maximize their functional goals (74 FR 39796). To comply with the regulation, required therapy treatments for IRF patients must begin within 36 hours from midnight on the day of admission to the IRF. For example, if a patient is admitted to the IRF at 2:00 p.m. on Tuesday, therapy treatment must be initiated by 12:00 p.m. on Thursday.

We proposed to revise § 412.622(a)(3)(ii) to require that IRFs must provide all therapy treatments and/or therapy evaluations to IRF patients in accordance with the 36-hour requirement. We believe it is necessary to make this revision in regulatory text as there had been prior sub-regulatory guidance that was posted by CMS in 2010, which may have created ambiguous interpretation of § 412.622(a)(3)(ii) as to whether only one therapy or all therapies must be initiated within 36 hours from midnight on the day of admission. Though the 2010 guidance has been removed from the website for quite some time, some providers still mistakenly refer to it. We believe that this revision to the regulatory language at § 412.622(a)(3)(ii) from ''[*t*]*he* required therapy'' to ''[*a*]*ll* required therapy'' (emphasis added) makes it unambiguous that, for an IRF provider to meet the reasonable and necessary standard for IRF claims, the entirety of the required therapies (that is, all) must be initiated in accordance with the 36-hour requirement, and not only one of the required therapies by that deadline.

Therapy evaluations are generally considered to constitute the beginning of all required therapy services and may count towards meeting the 36-hour requirement. However, all therapies must be initiated to be considered reasonable and necessary, not just one therapy. In summary, we proposed to revise § 412.622(a)(3)(ii) to state that all therapy treatments and/or therapy evaluations must begin no later than 36 hours after midnight on the day of admission. An IRF claim will not be considered reasonable and necessary (in accordance with section 1862(a)(1) of the Act) if it does not comply with this coverage criteria.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: We received many comments that supported our discussion of, and accompanying revision of the regulatory text regarding the 36-hour requirement, but most requested clarifications and/or certain considerations by CMS. Commenters stated the policy would positively impact patient care since early intervention is important for recovery. Others remarked that the revised language would reduce ambiguity in how the current 36-hour requirement is interpreted across the industry.

Many commenters approved of the policy's intent of prompt therapy initiation but requested that CMS clearly differentiate in the policy whether the 36-hour requirement applies to therapies documented in the preadmission screening (PAS) or to therapies that are ordered by the rehabilitation physician following admission (such as after the patient's History and Physical). These commenters stated that the PAS is typically compiled during the preceding acute care stay before more comprehensive assessments and therefore may not reflect the most current patient status at admission. These commenters also stated that the PAS documentation is not appropriate for determining compliance, whereas therapies ordered by the rehabilitation physician upon or after admission (for example, during the History and Physical) are more accurate and aligned with the patient's care plan. We received a comment requesting that CMS consider modifying the 36-hour requirement so it applies to the order date of therapy at any point during the patient's stay, not only at admission to support timely initiation of therapies. Several commenters stated that CMS should ensure that if the policy is finalized, it is implemented consistently via Medicare Administrative Contractors (MACs) and the Review Choice Demonstration (RCD).

Many commenters also suggested that CMS consider the approach to implementation of this policy and provide for clinical flexibility. They stated that most therapies are initiated in accordance with the 36-hour requirement but expressed that CMS should allow for greater flexibility for

smaller IRFs or IRFs who are facing staffing shortages (for example, shortages of rehabilitation physician and/or therapy disciplines). Multiple commenters requested exceptions or clinical judgement to be allowed for instances when clinical circumstances arise that preclude safe initiation of therapies for a patient (for example, a change in patient's tolerance for therapy). Commenters suggested CMS allow for 48–72 hours, as the revised 36-hour requirement could result in reduced access for patients if an IRF's staffing shortage cannot accommodate additional patients to be compliant. We received a couple of comments that requested that instead of *all* therapies, the policy apply to a patient's *core* therapy program over concerns the policy will be interpreted too broadly. Multiple commenters expressed that CMS should consider a 1-year delay in implementing the revised policy.

A number of commenters requested additional clarification on the 36-hour requirement, including how ''midnight on the day of admission'' is defined, whether therapies ordered later than the PAS (when medically appropriate) fall under the 36-hour requirement, and how CMS will determine compliance. A commenter requested that CMS provide more information on the definition of ''initiation,'' such as whether a therapy evaluation started but not completed within 36 hours of admission would be compliant with the policy.

Commenters recommended that CMS consider additional disciplines as part of implementation of the 36-hour requirement. Commenters suggested that Physician Assistants (PAs) be allowed to perform rehabilitation physician's duties, when it is within the PA's scope of practice. They stated that the 36-hour requirement adds to the burden that CMS is placing on rehabilitation physicians. Another commenter expressed that CMS should allow for recreational therapy (when medically appropriate) to count towards the 36-hour requirement.

Response: We appreciate the commenters' support for the discussion of, and accompanying revision of the regulatory text regarding the 36-hour requirement. As described at § 412.622(a)(3), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the beneficiary must require active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics) and one of the therapies must be either physical therapy or occupational therapy. Since IRF patients need multiple therapies, the 36-hour requirement in § 412.622(a)(3)(ii) states, the required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therefore, the use of the plural form of ''treatments'' means that *all* treatments shall be included, which we are codifying through the revision to the regulatory text of the 36-hour requirement. In alignment with the discussion in the FY 2010 final rule (74 FR 39796) and added to Section 110.2.2 of the Medicare Benefit Policy Manual,[11] we are including ''and/or evaluations'' to the regulatory text to specify that therapy evaluations are generally considered to constitute the beginning of the required therapy services.

We respect the implementation suggestions raised by commenters and have taken these into consideration. IRFs are required to provide patients with access to an intensive rehabilitation program (including physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) that consists of at least 3 hours of therapy at least 5 days per week in accordance with § 412.622(a)(3)(ii) [12] for an IRF claim to be considered reasonable and necessary. The 36-hour requirement ensures patients receive timely initiation of all therapies and/or evaluations to begin their recovery within an IRF. The 36-hour requirement ensures patients receive timely initiation of all therapies and/or evaluations to begin their recovery within an IRF.

We appreciate comments requesting clarification of the term ''midnight'' in the 36-hour requirement. We describe ''midnight of the day of admission'' as the midnight that follows admission to an IRF. This is clarified in the FY 2010 final rule (74 FR 39762) [13] in the example: ''a hypothetical patient admitted to the IRF at 4 p.m. on Friday would need to begin therapies by noon on Sunday.'' Therefore, midnight of the day of admission in this case would be 12 a.m. on Saturday, and all therapies would need to start no later than 12 p.m. on Sunday (up to 36 hours later). Additionally, we continue to determine compliance by conducting audits of IRFs' medical record documentation.

While several commenters suggested that we provide flexibilities for smaller IRFs and IRFs with staffing shortages, we did not propose to allow for flexibilities and are not finalizing any such flexibilities. We respectfully remind commenters, per 42 CFR 412.622(a)(3)(ii), CMS provides coverage for IRF patients who are expected to actively participate in and benefit from an intensive rehabilitation therapy program starting no later than 36 hours from midnight of the day of admission to the IRF. IRF claims for admitted IRF patients who cannot tolerate an intensive therapy program may be denied by CMS.

We agree that IRF patients have complex conditions that may evolve during a patient's stay after admission. As we have detailed in sub-regulatory guidance,[14] CMS authorizes contractors to grant brief exceptions (no more than 3 consecutive days) to the intensity of therapy requirement for unexpected clinical events or medical procedures during an IRF stay, as long as the situation is well documented and justified. We will continue to consider other exceptions to the 36-hour requirement and may propose them in future rulemaking.

We proposed and are finalizing in this rule revisions to § 412.622(a)(3)(ii) to require that *all* therapy treatments and/or therapy evaluations must begin no later than 36 hours after midnight on the day of admission. The 36-hour requirement applies to all therapies and/or therapy evaluations that are ordered at admission, which may occur by a rehabilitation physician concurring with the PAS or ordering additional therapies at admission. Additional therapies that the rehabilitation physician may order after the 36 hours following midnight of the day of admission are not part of the 36-hour requirement. However, we strongly encourage IRFs to initiate ordered therapies as soon as possible to provide a high quality of care to their patients.

We did not propose changing the PAS requirements and their application to the 36-hour requirement. CMS expects that the PAS must be conducted or updated within the 48 hours preceding admission in order to adequately capture the needs of the patient. Per 42 CFR 412.622(a)(4)(i)(B), the PAS must provide a comprehensive review of the patient's condition and their expected level of improvement to request the appropriate therapies for recovery and

[11] Accessed at *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c01.pdf.*

[12] *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(3)(ii).*

[13] *https://www.federalregister.gov/documents/2009/08/07/E9-18616/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal#p-409.*

[14] Medicare Benefit Policy Manual, Section 110.2.2—Intensive Level of Rehabilitation Services.

to avoid a delay in appropriate care. A rehabilitation physician is required to review a patient's PAS and provide their concurrence with the requested treatment *prior to admission.* The PAS determines whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary.

CMS amended the IRF coverage requirements in the FY 2021 final rule (84 FR 39054) [15] to allow non-physician practitioners (who are determined by the IRF to have specialized training and experience in IRFs) to perform one of the three weekly required face-to-face visits beginning during the patient's second week of care. However, we did not propose in this year's rule additional changes to duties that can be performed by a PA instead of a rehabilitation physician. Likewise, we did not propose the use of recreational therapy intervention as a possible therapy ordered through PAS. We will continue to monitor the role of PAs and recreational therapy in IRFs and to consider changes to policy via future public comment and rulemaking.

After consideration of public comments, we are finalizing our revision of the regulatory text for the 36-hour requirement to require that all therapy treatments and/or therapy evaluations must begin no later than 36 hours from midnight on the day of admission. All therapies must be initiated, not just one therapy, to be compliant with the policy. For example, if a patient is admitted to the IRF at 2:00 p.m. on Tuesday, all therapy treatments and/or therapy evaluations must be initiated by 12:00 p.m. on Thursday, or 36 hours after midnight (12 a.m.) following admission (in this example, midnight after admission is 12:00 a.m. on Wednesday). In response to comments, we are clarifying that, following the initial 36 hours after midnight of the day of admission (in this example after 12:00 p.m. on Thursday), any new therapy treatment and/or therapy evaluations that are ordered are not part of the 36-hour requirement. The 36-hour requirement is specific to therapies that have been ordered during the PAS and justifies the need for an IRF admission. We will provide guidance and training to assure the implementation of this policy is consistent across the industry and interested parties.

[15] *https://www.cms.gov/medicare/medicare-fee-for-service-payment/inpatientrehabfacpps/list-of-irf-federal-regulations-items/cms-1710-f.*

B. Updated Documentation of Current Functional Status in the PAS

IRFs are required to document a comprehensive PAS in accordance with 42 CFR 412.622(a)(4)(i) in order to indicate a patient meets the requirements for an IRF admission to be considered reasonable and necessary and ultimately, to be reimbursed for an IRF claim. As part of this policy (42 CFR 412.622(a)(4)(i)(B)), the PAS must ''include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination.''

While the patient's *prior* level of function is indicated as a requirement, we believe that for an appropriate POC to be developed for a patient, a patient's *current* functional status must also be documented in the PAS. The patient's current level of function provides important information to build a more complete picture of their rehabilitation trajectory and expected level of improvement while in the IRF.

We proposed to revise § 412.622(a)(4)(i)(B) to require that the patient's ''current functional status'' be documented in the patient's PAS in their medical record at admission and received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Some commenters expressed support for requiring documentation of the patient's *current* functional status in the PAS. Commenters in support remarked that this would be clinically valuable as it would give health care providers more insight into a patient's rehabilitation trajectory and needs. They stated it would improve care planning and tracking of recovery.

The majority of commenters opposed the proposal to require current functional status in the PAS in its current form because of potential clinical and compliance risks if finalized as proposed. They expressed that CMS should provide additional detail on functional data collection and compliance requirements in a future proposal. Commenters requested clarification on what type of assessment and level of detail would be required. We received a comment advising that therapeutic evaluations collected as part of the patient's POC are a more accurate baseline than the PAS and another comment we received stated the PAS represents a limited and time-specific snapshot of the patient's condition, typically based on referring medical personnel. Several commenters remarked that the PAS is used to determine IRF coverage and should not serve as a comprehensive functional assessment, such as the IRF–PAI. They expressed that CMS should make clear that if there were any differences between a patient's current functional status documented in the PAS and IRF admission assessments, an IRF claim would not be denied.

Commenters provided a range of suggestions about implementation of the current functional status requirement. We received a comment to consider greater flexibility in the policy's implementation for smaller IRFs or IRFs facing staffing shortages. Several commenters said that documentation of current functional status in the PAS should be used as a screening tool to inform IRF level of care, not as a comprehensive assessment that is used for payment or case-mix groupings. An additional comment expressed that CMS should consider utilizing IRF–PAI data elements for assessment in order to promote data standardization and enable valid comparisons of the patient's function in the PAS and later in their IRF stay. Other commenters were opposed to using the IRF–PAI to assess functional status. A couple of commenters stated that CMS should allow for flexibility in methods of collecting current functional status data on the PAS, including chart review or brief observation.

Response: We appreciate the commenters' input about our proposal to require current functional status to be documented in the PAS. We will not be finalizing this proposal as we pursue adding increased specificity to the policy. We may take into consideration the public comments received to inform future rulemaking on this topic.

C. Initial Interdisciplinary Team Meeting

1. Background

During the IDT meeting, all members of a patient's IRF care team review the patient's progress toward their rehabilitation goals, while making recommendations for therapy changes to support discharge goals

(§ 412.622(a)(5)). These goals are part of the patient's individual POC which collates assessments from each therapy discipline treating the patient and includes the patient's medical prognosis, anticipated interventions, functional outcomes, and discharge destination. Per § 412.622(a)(4)(ii), the POC must be developed by a rehabilitation physician and documented in the patient's medical record or electronic health record by day 4 of the patient's admission to the IRF.

The current IDT meeting policy (42 CFR 412.622(a)(5)) states that IDT meetings must occur ''at least once per week throughout the duration of the patient's stay,'' with a ''week'' defined as a period of 7 consecutive calendar days beginning with the date of admission to the IRF'' (§ 412.622(c)). In 2010, CMS posted guidance to the IRF PPS website that was misinterpreted to indicate that the initial IDT meeting may occur on day 8 from the day of admission, which is not aligned with the regulatory text cited previously in this section. CMS removed this document in December 2023 and noted its removal in an announcement on the IRF PPS homepage, which pointed providers to reference more accurate resources provided by CMS.

2. Initial Interdisciplinary Team Meeting

Under the current IDT policy (§ 412.622(a)(5)), IRF patients may have only one IDT meeting occur prior to discharge, which raises concern about the level of coordinated interdisciplinary care a patient is receiving. The IDT meeting is a key aspect of the interdisciplinary care of an IRF patient as it provides the opportunity for the care team to review together the patient's care and progress, and to ensure the POC is updated as needed to accurately reflect the patient's needs. As a result of the prior guidance provided, it is possible for an IRF patient to receive up to 7 days of care in an IRF without their full care team coordinating their treatment or discussing progress towards the patient's goals as outlined in the POC. This could be particularly concerning as the patient is likely to experience rapid improvement or decline in functioning within the first 7 days.

By not providing a timely initial IDT meeting with the care team's input on the patient's progress, the team may be providing suboptimal treatment or inadvertently worsening the patient's health outcomes. Also, given the average length of stay in an IRF is typically between 12 to 14 days, for a patient who has their first IDT meeting on day 7, it is likely that the IDT meeting would focus on discharge planning rather than making timely updates to the patient's POC based on their progress. Per § 412.622(a)(4)(ii), an individualized overall POC must be developed by a rehabilitation physician with input from the interdisciplinary team on or before 4 days of the patient's admission to the IRF and documented in the patient's medical record or electronic health record. By not making more timely checks and updates within the IDT meeting on the patient's progress, and related POC updates, patients are at risk for ineffective care that may lead to delayed improvements.

Patient example: A 68-year-old male patient is admitted to an IRF with an ischemic stroke causing mild hemiparesis, mild aphasia, and dysphagia. His admission goals were to increase his mobility, independence with activities of daily living (ADLs), and safety with swallowing in order to be discharged home to his family. The patient's POC includes: a physical therapist (PT) to work on gait training and balance; an occupational therapist (OT) to address his independence with self-care and dressing; and a speech-language pathologist (SLP) to manage the aphasia and swallowing. During the patient's course of stay, the PT, OT and SLP have limited communication with one another. By the time the patient's IDT meeting occurs on day 7 of his stay, the PT has noted the patient is steady with transfers using a walker and requires minimal assistance to ambulate with his walker. Despite the PTs notes, the OT is now training the patient on ADL tasks that require him to stand without support. The patient has been steady when performing these tasks for brief periods of time but needs to rest often by sitting down. The SLP is providing the patient with nectar-thick liquids per the swallowing plan but has not communicated the patient's fatigue levels or the patient's need for safety cues when swallowing to the rest of the team. The patient's IDT meeting on day 7 focuses on his discharge planning with the rehabilitation physician noting the patient can safely ambulate independently with his walker and ADLs as he is unaware of the inconsistencies in the patient's presentation across the OT, SLP, and PT therapy sessions. As such, the patient returns home with his wife after 11 days in the IRF. Within two days, the patient sustains a fall while transferring from the toilet resulting in a hip fracture. He is readmitted to the acute care hospital with aspiration pneumonia due to coughing and choking during meals and hip fracture due to difficulty ambulating with his walker.

In the example, if the initial IDT meeting had occurred earlier than day 7, the patient's POC could have been adjusted to better match his functional progress. Additionally, his care team could have discussed ongoing concerns regarding his fatigue, balance, and swallowing to coordinate treatment. An earlier IDT meeting may have prevented this patient's fall and hospital readmission.

In an effort to continuously improve patient-centered care, we believe the first IDT meeting should occur earlier than day 7 of a patient's stay, which is current policy. This change will ensure patients are receiving coordinated, interdisciplinary care aligned with their POC and tailored in its intensity to the patient's recovery progress. We proposed to revise § 412.622(a)(5)(ii) to specify that the initial IDT meeting shall occur on or before the fourth day from midnight on the day the patient is admitted to implement appropriate treatment services; establish or review the patient's stated rehabilitation goals; and identify any problems that could impede goals. The initial IDT would be in coordination with admission and the POC. Following the initial IDT meeting, we proposed that a patient's subsequent IDT meetings occur weekly (for example, within 7 days from the prior IDT meeting). See Figure 1 that is revised in this final rule to clarify the requirements for the timeline of the IDT meeting. Table 8 for this final rule also provides examples of when IDT meetings occur based on the date the prior IDT was conducted. In addition to the revisions to § 412.622(a)(5)(ii), we proposed to redesignate paragraph (a)(5)(iii) as paragraph (a)(5)(iv) and add a new paragraph (a)(5)(iii) to clarify that the initial IDT meeting shall determine the cadence of patient's subsequent IDT meetings. We also proposed to revise the definition of ''Week'' that appears in § 412.622(c) to specify that, for purposes of § 412.622, a ''week'' means a period of 7 consecutive calendar days.

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REVISED FIGURE 1: Initial Interdisciplinary Team Meeting Policy in Effect for FY 2027

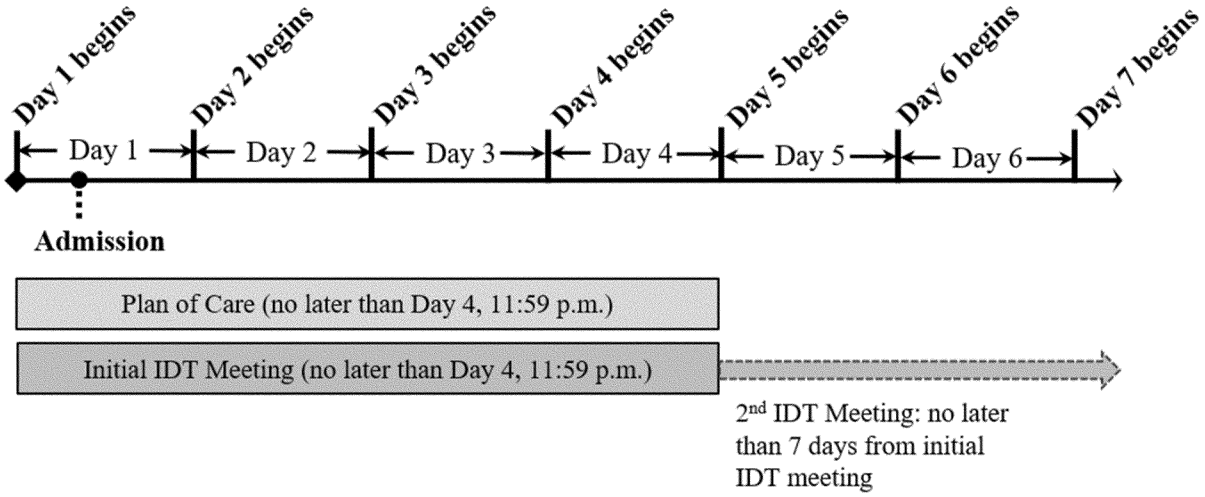

TABLE 8: Compliant and Non-Compliant IRF Patient Examples of IDT Timelines

Patient	Length of Stay	Initial IDT	IDT #2	IDT #3	Compliant?
A	4 days	day 2	N/A	N/A	Yes
B	10 days	day 4	day 9	N/A	Yes
C	6 days	day 2	day 5	N/A	Yes
D	14 days	day 2	day 11	N/A	No – the initial IDT is compliant, but IDT #2 is non-compliant as there are more than 7 days between the initial IDT and IDT #2.
E	20 days	day 4	day 11	day 19	No – IDT #3 is non-compliant as there have been more than 7 days since IDT #2. The initial IDT and IDT #2 are compliant.
F	16 days	day 6	day 13	N/A	No – the initial IDT is non-compliant as there were more than 4 days between admission and the initial IDT.

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In the proposed rule, we stated that in requiring the patient's first IDT meeting to occur by day 4, we believe the interdisciplinary team can coordinate care and provide treatment updates more frequently than once during a patient's stay, which may lead to improved quality of care and health outcomes. As discussed in the FY 2010 rule (74 FR 39762), conducting the IDT meeting ''for each IRF patient within the first 4 days of admission to develop the overall plan of care would be good practice.''

To assess the impact of the proposed policy, we conducted a simulation exercise. If we assume that IRFs hold a formal IDT meeting on a weekly basis (per the current policy) to address their caseload and the prognoses of their patients, an estimated range of 2.1 to 3.8 percent of IRF patients discharged between FY 2015 through FY 2023 experience zero IDT meetings during their stay. If we account for patients who were admitted on the day of the IDT meeting but too late to be discussed at the meeting, the number of cases with zero IDT meetings during the stay will increase from 4.2 to 4.8 percent. By CMS implementing a policy requiring that the patient's first IDT meeting occurs by day 4 of their stay, the percentage of cases that did not have an IDT meeting would decrease to 1 percent. After the initial IDT meeting, IRFs will need to conduct subsequent IDT meetings beginning on the 7th day from when the last meeting occurred.

We conducted an estimated impact of the proposed initial IDT policy on IRFs. To determine the resources needed for one IRF meeting, we first identified the salaries of the key personnel who attend IDT meetings using the 2024 Bureau of Labor Statistics' (BLS) national average wages per hour. For conservative estimation purposes, we assumed one of each of the following disciplines attend IDT meetings: rehabilitation physician, PT, OT, SLP, nurse coordinator (filled by an RN), social worker, and rehabilitation unit manager (filled by an NP). If the proposed initial IDT meeting policy is finalized, we assume that most IRFs (depending on the volume of patients) will increase the frequency of meetings to meet this change. For example, if an IRF has a patient

admitted on a Tuesday, but the team's usual IDT meetings occur on Mondays, then the IRF will have to meet again by the patient's day 4 (Friday in this example) to comply with the new policy. We estimated that a 1-hour IDT meeting would cover approximately 12 IRF patients (5 minutes per patient), resulting in $399.06 per 60-minute IDT meeting. Assuming the IDT meetings would be 1-hour in duration, for IRFs that move from once to the twice weekly IDT meeting frequency will face an additional approximate cost of $399.06 per week.

We received public comments on this proposal. The following is a summary of the comments we received and our responses.

Comment: Some commenters supported the 4-day initial IDT policy. Commenters remarked that the policy would codify best practices and improve coordination of care among the interdisciplinary team. They stated that the policy would enable earlier discharge planning and thereby avoid unnecessary longer lengths of stay. Additionally, commenters stated that the revised IDT policy would improve patient outcomes and health system throughput.

Response: We appreciate the commenters' support of the 4-day initial IDT policy. We agree with commenters that the proposal codifies best practices and promotes patient-centered care while also creating operational alignment with admission and the POC requirements.

Comment: Several commenters requested clarification from CMS regarding the timing requirements of the proposed initial IDT policy and stated that the provided timeline diagram was unclear. Commenters expressed that CMS should better define midnight and what is considered day 1 to begin the timeline for both the initial IDT policy and the POC to occur by day 4. We also received a comment that requested that the redesignated paragraph 42 CFR 412.622 (a)(5)(iii) that is now paragraph 42 CFR 412.622 (a)(5)(iv) be included in the regulation text in the final rule.

Response: The initial IDT meeting would be in coordination with admission and the POC. In response to commenters, we clarify that day 1 is the day of admission—hence, if a patient is admitted on a Thursday, they would have until end of day on Sunday (4 days from Thursday) to conduct the patient's initial IDT meeting (refer to the revised Figure 1). As with the initial IDT meeting, day 1 for the POC requirement also starts the day of admission to an IRF.

In response to the commenter who said CMS should include the paragraph 42 CFR 412.622(a)(5)(iii) that was redesignated as paragraph 42 CFR 412.622 (a)(5)(iv), we respectfully remind the commenter that the redesignated paragraph has no revisions. It will continue to read as follows, ''The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record.''

Comment: Multiple commenters provided suggestions on how to implement the initial IDT policy. Many commenters stated that the documentation of the initial IDT meeting should replace the POC documentation. A comment was also submitted that expressed that CMS should allow the day of admission to be day 0 with regards to the timing of the initial IDT and POC as new patients are typically admitted late in the day from acute care hospitals. Multiple commenters stated CMS should allow all of the patient's care team to attend the IDT meetings remotely, not only the rehab physician, per the current policy.

We received many comments requesting flexibility in implementing the proposed policy for facilities facing staffing shortages and high patient volumes. Additionally, commenters requested that CMS provide exceptions in the case of situations that require the initial IDT meeting to occur later than day 4, as long as they document well the circumstance and provide details of other interdisciplinary coordination occurring. Other commenters suggested that CMS delay implementation (1 year or more) of the policy to enable providers to make necessary adjustments and provide training. Several commenters suggested CMS allow the initial IDT meeting to fall on the next business day in the instances when patients are admitted later in the week and day 4 is on the weekend or a holiday. These commenters voiced concern that not all of a patient's care team may be present on the weekend, which could result in less informed care decisions occurring during the IDT meeting. Additionally, they stated that, in these instances when meetings occurred on the weekend without the full care team, they be more for compliance reasons rather than providing clinical value to the patient. We also received a comment that expressed that CMS should allow PAs to conduct IDT meeting activities that are within their scope of practice under applicable state laws.

Response: We appreciate commenters' suggestions for implementing the proposed initial IDT policy and may take these into consideration in the future. The documentation of the initial IDT meeting should be separate from documentation of a patient's POC in the medical record. The initial and subsequent IDT meetings will provide the opportunity for the care team to collaborate on the patient's POC and progress, and to ensure the POC is updated as needed to accurately reflect the patient's needs.

We consider the day of admission to be day 1 for the initial IDT policy in alignment with the POC. Both the initial IDT meeting and the patient's POC must be documented in the patient's medical record or electronic health record by day 4. We recognize day 4 may occur over a weekend or a holiday with admissions that occur later in the week. We understand commenters' concerns that the timeframe allotted for the initial IDT policy may not align with the standard clinical practices of both hospital-based and freestanding IRFs. While we continue to believe that the 4-day initial IDT policy (as compared to the currently-in-effect 7-day IDT policy) better ensures patient-centered, seamless provision of care for patients to enable their timely recovery and discharge from an IRF, in response to feedback from commenters, we are not finalizing our proposed regulatory revision to require that the first IDT meeting shall occur on or before the fourth day from midnight on the date the patient is admitted. We are, however, finalizing the proposed requirement that the first IDT meeting shall occur on or before the fourth day from the date the patient is admitted. As such, for admissions on or after October 1, 2026, for a patient admitted on a Thursday, the initial IDT meeting for that patient would need to occur before end of day on Sunday.

At this time, per § 412.622(a)(5)(i) we are only allowing rehabilitation physicians to participate in IDT meetings remotely—all other team members must attend in-person. We will monitor the implementation of the proposed initial IDT policy and possibly consider amending the remote policy, through notice and comment rulemaking, as appropriate.

In consideration of the comments that requested that PAs be allowed to perform medical duties that are currently only allowed to be performed by a rehabilitation physician, we believe the IDT meetings should be led by rehabilitation physicians who have greater expertise and training in inpatient rehabilitation than PAs. Rehabilitation physicians play an important role in decisions about

patients' plans of care and discharge, both of which require extensive experience.

Comment: Most commenters expressed concern about the proposed 4-day initial IDT policy. Commenters stated that the IDT meeting is one component of an already interdisciplinary approach to patient care beginning at admission. Commenters stated that current practice at IRFs provides ongoing collaboration and coordination of patient care which was unaccounted for in the proposed policy. The commenters remarked that the CMS' concerns mentioned about limited care team communication or POC updates were not based on the realities of care provision in IRFs.

Multiple commenters expressed that the policy would increase administrative burden by being duplicative to the coordination required for drafting the individualized POC and other forms of team communication that occur early in a patient's stay (for example, team huddles, meetings with the patient's family), without evidence of clinical benefit. The commenters remarked that the proposal contradicts CMS' goals of improved patient-centered care as the additional meetings would detract from time spent directly with patients. They stated that adding burden and procedural steps in an already tight initial timeframe is particularly concerning due to current staffing shortages and resource constraints that IRFs are facing, and could result in unintended consequences, claim denials, or reduce access for patients. Additionally, commenters remarked that the policy is not aligned with CMS' initiatives aimed at reducing burden in hospitals. A commenter stated that it is unclear why CMS is proposing this policy when current Medicare coverage criteria is highly detailed and already requires interdisciplinary coordination.

Many commenters in opposition to the initial IDT policy preferred the 7-day IDT policy remain. A commenter stated that the 7-day policy should be retained with provider flexibility allowed in certain circumstances (and when compliant with POC). Other commenters believed the current 7-day IDT timeframe aligns well with the 36-hour requirement and POC timeline. They stated it enables initiation of therapy and treatment so that clinicians can gauge patient recovery and necessary POC modifications in preparation for the IDT meeting.

Commenters voiced concerns that the initial IDT policy as proposed is overly rigid and would cause significant operational challenges and resource burden without proven clinical benefit to the patient. Commenters stated if an initial IDT meeting has to occur over the weekend, it would be difficult to guarantee the patient's care team could be in attendance. Others remarked that the earlier timeline for the initial IDT policy meant that initial IDT meetings might have to be held before standard outreach to a patient's family or initial therapy evaluations have been conducted or cause a delay in more urgent medical priorities that may occur early in a patient's stay. A commenter discussed that the 3-day assessment period for completing the IRF–PAI admission is necessary for accurate case mix group assignments and estimated length of stay.

Multiple commenters stated the IDT policy would cause operational burden by requiring IRFs to hold 3–4 IDT meetings per week to be compliant. Additionally, they said the policy will add considerable strain to rehabilitation physicians' schedules, thereby detracting from direct patient care. Commenters stated that having a 2nd IDT meeting within 7 days of the initial IDT meeting could result in discussing the same patient more than once in 1 week.

Several commenters remarked that CMS' estimates of the amount of time required for each patient discussed in IDT meetings was inadequate to review the patient's clinical progress and make revisions to their goals or POC. They stated that IRF patients are often medically complex which may require intensive interdisciplinary coordination or attendance of additional care disciplines (for example, Registered Dietician Nutritionists), which last longer than the estimated average of five minutes per IDT meeting. As such, they commented that CMS' resource burden estimates as a result of the policy were flawed.

Response: The proposed initial IDT policy would require IRFs to conduct a patient's first IDT meeting on or before the fourth day from midnight on the day the patient is admitted. While additional documentation of the patient's recovery or changes to the patient's POC may be a result of this policy, we believe this burden is minimal compared to ensuring patients receive care aligned with their recovery progress which will lead to improved outcomes.

As proposed, the policy requires IRFs to conduct the first IDT meeting for a patient on or before the fourth day from midnight on the day of admission. Therefore, if some of the care team is unavailable on a weekend, the IRF can make appropriate arrangements to convene the initial IDT meeting with the full care team on a weekday prior to the weekend, if it occurs on or before the fourth day. For example, for a patient admitted on a Thursday (whose initial IDT would be due by day 4, or Sun at 11:59 p.m.), the IRF could conduct the initial IDT meeting on Friday to accommodate the care team's schedule if they cannot be part of a weekend IDT meeting.

We do not believe the earlier timeline for the proposed 4-day initial IDT policy will cause initial IDT meetings to occur prior to therapy evaluations. By day 4, the patient's care team should have completed therapy evaluations, observed actual participation, identified barriers to treatment, assessed tolerance and endurance, and begun implementation of the rehab program; as such, the care team will have enough information about the patient to conduct the IDT meeting. Holding the initial IDT meeting by day 4 will allow for earlier identification of clinical, functional, or psychosocial barriers affecting the patient's progress and timely adjustments to their treatment plan.

As compared to smaller team huddles or individual communication between care team members, while these are important aspects of patient management, we believe the IDT meeting serves a different purpose by providing a structured meeting with the entire care team convened to review the patient's care and to collaboratively make care decisions or modifications. The IDT meeting enables the team to assess the patient's response to treatment, progress towards their goals, barriers to rehabilitation, and continued appropriateness of the treatment plan. In response to changes in the patient's medical presentation or recovery progress, an initial IDT meeting within 4 days of the day of admission enables timely updates to be made to the POC in response to the patient's needs.

We agree that the initial IDT meeting policy may result in additional IDT meetings occurring at IRFs each week. However, the improvement in quality of care and recovery trajectory that may result from the initial IDT meeting occurring earlier during the patient's stay (as compared to up to 7 days after admission) is vitally important for patient-centered care and aligning to the POC. Following a patient's initial IDT meeting, IRFs may conduct the subsequent IDT meeting up to 7 days after. Depending on the cadence of IDT meetings by an IRF, it is possible that a patient will be reviewed in an IDT meeting more than once per week or that IRFs will have to hold two IDT meetings on patients per week.

However, we believe more collaboration among a patient's care team regarding their recovery will be beneficial to the patient.

We respectfully remind commenters that our estimation of the resources needed for additional IDT meetings was conducted via a simulation exercise. Across IRFs, there will be variation in resource use by patient acuity and by different operational processes.

After consideration of public comments, we are finalizing the 4-day IDT policy with a clarification. We will revise § 412.622(a)(5)(ii) as proposed to specify that the initial IDT meeting shall occur on or before the fourth day the patient is admitted to implement appropriate treatment services; establish or review the patient's stated rehabilitation goals; and identify any problems that could impede goals. The initial IDT would be in coordination with the development and timing of the patient's start of therapy (per the 36-hour requirement) and the POC. To clarify, day 1 is considered the day of admission—hence, if a patient is admitted at 1 p.m. on a Thursday, they would have until Sunday at 11:59 p.m. (4 days after admission) to conduct the patient's initial IDT meeting (refer to the revised Figure 1). Similar to the initial IDT meeting, day 1 for the POC requirement also starts the day of admission to an IRF—therefore, if a patient is admitted at 3 p.m. on a Tuesday, the POC must be developed by 11:59 p.m. on Friday (4 days after admission). Following the initial IDT meeting, we are finalizing that a patient's subsequent IDT meetings occur weekly (for example, within 7 days from the prior IDT meeting). In addition to the revisions to § 412.622(a)(5)(ii), we will redesignate paragraph (a)(5)(iii) as paragraph (a)(5)(iv) and add a new paragraph (a)(5)(iii) to clarify that the initial IDT meeting shall determine the cadence of patient's subsequent IDT meetings. We are finalizing the proposed revision to the definition of ''Week'' that appears in § 412.622(c) to specify that, for purposes of § 412.622, a ''week'' means a period of 7 consecutive calendar days. However, as discussed earlier in this section, we are not finalizing the requirement that the first IDT team meeting occur on or before 4 days from midnight of the date of admission; instead, the initial IDT team meeting must occur within 4 days of the date of admission.

IX. Request for Information Regarding Future IRF Payment Reform

CMS is exploring opportunities to modernize the IRF PPS established in 2002 (66 FR 41316) to better reflect evolving clinical practice and align more closely with other post-acute care settings. This includes potential refinements to clinical categories and comorbidity. The recommended deadlines of 60 or 90 days after the end of the quarter would not achieve our goal of providing more timely data to consumers and IRFs, as posting of public reporting would fall into the same quarterly refresh that it is in currently. For example, for Q1 groupings. In this section, we provide an overview of the current IRF PPS patient classification system. In the proposed rule, we requested input on future payment reforms to enhance and modernize the IRF payment structure. We provide a summary of the comments we received and our responses in sections IX.B.1 and IX.B.2. of this final rule.

A. Background

Under the IRF PPS, providers report an Impairment Group Code (IGC) in Item 21A of the IRF–PAI to identify the primary reason the patient requires IRF care. Each IGC maps to a single Rehabilitation Impairment Category (RIC), which serves as the first level of classification in the payment system. The CMS grouper uses the RIC to assign the patient to a CMG based primarily on functional status at admission and, for certain CMGs, age.

Functional status is a key predictor of resource use under the IRF PPS. From FY 2002 through FY 2019, CMG assignment relied on motor and cognitive scores derived from the FIM™ instrument. In the FY 2019 final rule (83 FR 38514), CMS removed the FIM™ instrument and associated Function Modifiers and adopted IRF–PAI Quality Indicator items to reduce provider burden. Beginning in FY 2020, CMGs have been assigned using functional scores derived from these IRF–PAI assessment items.

CMGs are further refined to account for clinical complexity. Patients may be assigned to comorbidity tiers that adjust payment to reflect higher expected resource use. Additional payment adjustments apply for special circumstances, such as very short stays or death.

The IRF PPS currently includes 21 Rehabilitation Impairment Categories and 17 associated Impairment Group Codes, as established in the FY 2002 final rule (66 FR 41316). IGCs are represented by one or two-digit codes, sometimes extended with decimals to identify more specific subgroups.

Additional information is available in the FY 2002 (66 FR 41316), FY 2006 (70 FR 47880), FY 2007 (71 FR 48354), and FY 2021 (85 FR 48424) IRF PPS final rules.

B. The Need for IRF Payment Reform

Experience from other Medicare payment reforms demonstrates the importance of aligning payment with patient characteristics and expected resource use, rather than service volume, while maintaining strong safeguards against unintended coding or behavioral responses. These reforms highlight the need for regular recalibration using current data, thoughtful and phased implementation of structural changes, and monitoring to protect beneficiary access. Applying these principles to IRF payment reform supports continued refinement of CMGs, functional scores, and comorbidity adjustments to improve payment accuracy and ensure program integrity.

CMS believes refinements to the IRF clinical categories and comorbidity groupings are necessary to support continued payment reform under section 1886(j) of the Act, which would contribute to overall payment reform. CMS must ensure that the IRF PPS reflects changes in patient complexity and advances in rehabilitation care since the system's implementation in 2002. These refinements are intended to better align payment with patient characteristics and resource use, strengthen the relationship between spending and value, and support CMS's broader goal of a more consistent and coordinated approach to post-acute care (PAC) payment and delivery.

As with any case-mix methodology, shifts in documentation, coding practices, or assessment completion may influence measured case-mix independent of true changes in patient acuity. By adopting more standardized, diagnosis-based classification approaches across PAC settings, CMS aims to improve consistency, support care delivery reform, and position the IRF PPS for future payment reforms that better reflect patient complexity and value. Furthermore, these potential refinements would move the IRF PPS toward diagnosis-driven grouping methods similar to those used in other Medicare payment systems, including the Inpatient Psychiatric Facility PPS (IPF PPS) and the SNF Patient-Driven Payment Model (PDPM) finalized in the FY 2019 SNF PPS final rule (83 FR 39162).

MedPAC's recent analyses further support the need for refinement. In multiple Reports to the Congress on Medicare Payment Policy (March 2023, March 2024, March 2025, and March 2026), MedPAC identified persistent

differences in profitability across clinical categories, which could provide incentives for admitting specific diagnoses to improve profitability. MedPAC also found that within RICs, higher patient severity—measured by functional status and comorbidities—is associated with higher payment-to-cost ratios, and that case mix varies meaningfully by IRF ownership and type, particularly for high-volume conditions such as stroke, other neurological conditions, and debility. These findings underscore the importance of refining IRF clinical categories and comorbidity groupings to better reflect patient severity and improve alignment between payments and resource use. In this RFI, we sought interested parties' input on potential approaches to ensure that payments under a revised IRF PPS appropriately reflect underlying patient severity and costs, particularly in the event of systematic changes in coding or documentation that are not accompanied by corresponding changes in clinical complexity or resource utilization.

1. Potential Changes to IRF Patient Clinical Classification

As previously discussed, the IRF PPS currently relies on 17 major category IGCs, comprising 85 specific IGCs, finalized in the FY 2002 IRF PPS final rule (66 FR 41316) to classify each patient into one of 21 distinct Rehabilitation Impairment Categories (RICs). Under this framework, up to three ICD–10–CM etiologic diagnosis codes are mapped through a multi-step process—from IGCs to RICs to CMGs—to determine payment. Over time, this layered classification approach has created opportunities for misalignment among the patient's primary reason for IRF admission, the clinical care delivered, and the resulting payment, particularly as diagnostic coding practices and patient complexity have evolved.

To address these limitations, CMS is considering a fundamental refinement to IRF patient classification by modifying how primary diagnoses are mapped to clinical categories. Specifically, CMS has leveraged the existing clinical categories recently implemented under the SNF PDPM to develop a preliminary set of IRF-specific clinical categories. These categories would modernize IRF patient classification by replacing the current mapping of etiologic diagnoses to IGCs and RICs with a comprehensive and exhaustive crosswalk from ICD–10–CM diagnosis codes directly to IRF PPS clinical categories. This approach would strengthen alignment between diagnosis, patient severity, and payment; improve consistency across post-acute care settings; and support CMS's broader objectives of payment accuracy, transparency, and value-based care.

Table 9 provides the 15 valid IRF clinical categories for consideration. Using a complete ICD–10–CM to clinical category crosswalk, patients are classified into clinical categories by the ICD–10–CM code reflecting the primary reason for the IRF stay.

TABLE 9: Potential IRF Clinical Categories*

Potential IRF Clinical Categories
Acute Infections
Acute Neurologic - Brain/Cranial Nerve
Acute Neurologic - Peripheral Nerve/Muscle
Acute Neurologic - Spinal Cord
Cancer
Cardiovascular and Coagulations
Major Joint Replacement or Spinal Surgery
Medical Management
Non-Orthopedic Surgery
Non-Surgical Orthopedic/Musculoskeletal - Infection
Non-Surgical Orthopedic/Musculoskeletal - Injury
Non-Surgical Orthopedic/Musculoskeletal - Peripheral Nerve/Muscle
Non-Surgical Orthopedic/Musculoskeletal - Rheumatoid/Structural
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
Pulmonary

* Note: these clinical categories align with the 10 SNF PPS clinical categories and expand on the Acute Neurologic and Non-Surgical Orthopedic/Musculoskeletal categories, as they accounted for a high proportion of IRF stays and were too broad, which prompted additional breakdown to better reflect IRF case-mix and allow for a more tailored and meaningful distribution of IRF stays.

We solicited public comments on the potential use of these clinical category assignments under the IRF PPS to classify a patient for payment purposes. CMS is exploring alternatives to how primary diagnoses are mapped to clinical categories in the current IRF PPS, which is documented in a technical report available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/research.* The following is a summary of the public comments received and our responses.

Comment: Several commenters expressed conditional support for CMS' efforts to improve payment accuracy and better reflect patient complexity, while emphasizing the need for additional analysis and interested party engagement before implementation.

Supportive commenters favored greater standardization of classification systems to improve consistency across post-acute care settings and better account for medically complex patients. They acknowledged limitations in the current IRF payment system and supported continued evaluation of reforms that could improve fairness, efficiency, and reimbursement accuracy. Some commenters also recommended refinements to clinical categories, including adding cancer as a distinct category and improving category definitions overall.

Supportive commenters still expressed many of the concerns described by commenters who unconditionally opposed the RFI on payment reform. Commenters expressed significant concerns regarding the underlying research, methodology, financial impact, and implementation approach. Commenters stated that CMS had not provided sufficient data, methodology, ICD–10 crosswalks, or operational guidance to evaluate the potential effects of the changes. They emphasized the need for collaboration with providers and technical experts prior to implementation and stated that CMS should provide adequate lead time for any future transition. Many commenters disagreed with aligning IRF payment methodologies with SNF PDPM-based clinical categories. They stated that IRFs serve a clinically distinct population requiring more intensive, interdisciplinary rehabilitation and that a SNF-based framework would fail to capture patient complexity, rehabilitation intensity, and functional needs. Commenters expressed concern that reliance on a single primary diagnosis and broad clinical categories could underrepresent the cumulative impact of multiple conditions and inadequately reimburse providers caring for medically complex patients. They stated that these changes could reduce reimbursement and limit therapy services, potentially worsening patient outcomes. They also expressed concern that changes could restrict access to IRF care and shift costs elsewhere in the healthcare system. Some commenters suggested alternative approaches, including expanded RICs, greater reliance on motor and cognitive function measures, multidisciplinary intensity tiers, and modernization of the 60 percent rule.

Commenters also expressed confusion about the overall rationale and process underlying the potential reforms. Many stated that CMS had not clearly identified a policy problem, provided sufficient evidence to justify major structural changes, or engaged interested parties in the process. Additionally, commenters highlighted the significant coding, administrative, and information technology changes that would be required without clear evidence that the reforms would improve outcomes or payment accuracy.

Response: We appreciate the comments regarding the potential clinical category assignments to classify a patient under the IRF PPS for payment purposes. Commenters expressed a range of views that support and oppose CMS' initial concept to how primary diagnoses are mapped to clinical categories in the current IRF PPS. We will provide information throughout the development of the clinical category mapping and engage with interested parties. Commenters raised questions regarding the policy rationale, need to distinguish the difference between the IRF and SNF patient populations, and payment accuracy.

After consideration of the comments received, we recognize the importance of further evaluating the issues raised by interested parties. We will continue to analyze the clinical category assignments, including its potential impacts on payment accuracy, beneficiary access, and provider behavior, and will consider interested party feedback as we assess potential future refinements to the IRF clinical categories.

2. Potential Changes to IRF PPS Comorbidities

Drawing on the comorbidity scoring methodology used by the SNF PDPM Non-Therapy Ancillary (NTA) component, CMS developed a preliminary comorbidity scoring and binning approach for the IRF PPS accounting for both the severity and the number of comorbid conditions. This would also support alignment across post-acute care payment systems. Under this framework, CMS identifies comorbidities associated with higher IRF costs using multiple sources, including Hierarchical Condition Categories (HCCs), Prescription HCCs (RxHCCs), IRF–PAI items, and selected custom conditions. Each comorbidity would contribute to a weighted score reflecting its relative impact on resource use, similar to the methodology applied under the SNF PDPM NTA system.

As shown in Table 10, comorbidity scores would then be grouped into one of 6 comorbidity score bins: a comorbidity score of 0, 1, 2, 3, 4–5, and 6 or higher. Each bin groups IRF stays by corresponding comorbidity score based on estimated similarities in costs. These scoring and grouping refinements would align spending and value through improved accuracy while also aligning IRF PPS more closely with other PAC payment systems.

TABLE 10: Potential Comorbidity Score Bins*

Potential Bins	Potential Comorbidity Scores in Each Bins
Bin 1	Comorbidity Score of 0
Bin 2	Comorbidity Score of 1
Bin 3	Comorbidity Score of 2
Bin 4	Comorbidity Score of 3
Bin 5	Comorbidity Score of 4 or 5
Bin 6	Comorbidity Score of 6+

*Note: Comorbidity bins group comorbidities by similarities in cost.

We solicited public comments on the potential use of comorbidity scores and score bins under the IRF PPS to categorize comorbidities for payment purposes. CMS is exploring alternatives to the tier comorbidity methodology of the current IRF PPS and relative performance to the current system, which is documented in a technical

report. For more details, including a list of the selected comorbidities and corresponding scores, this technical report is available at *https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-rehabilitation/research.* The following is a summary of the public comments received and our responses.

Comment: Comments on the alternative to the IRF comorbidity scoring methodology were mixed, with limited support for the concept of modernization and substantial concern about the specific approach CMS described. Several commenters agreed with the broader goal of improving payment accuracy by better accounting for patient complexity and cumulative comorbidity burden. Supporters stated that a weighted comorbidity scoring system could potentially provide a more nuanced assessment of resource needs than the current 3-tier adjustment structure and could improve consistency across post-acute care payment systems.

Many commenters stated that CMS has not provided sufficient justification, methodological detail, or evidence that the alternative scoring approach would improve payment accuracy over the current comorbidity tier system. Commenters expressed caution against adopting a PDPM-based methodology derived from the SNF setting without demonstrating that it appropriately reflects the clinical complexity and resource requirements of IRF patients. They expressed that the alternative approach lacked transparency regarding the underlying methodology, ICD–10 crosswalks, and comorbidity groupings, making it difficult for interested parties to evaluate potential payment and operational impacts.

Many commenters expressed concern that the alternative scoring system could underrecognize important comorbidity burdens. Commenters stated that the methodology would exclude lower-cost comorbidities that score zero points individually, even though multiple lower-cost conditions may collectively drive substantial resource use. One analysis highlighted that more than one-third of IRF stays currently assigned to the lowest comorbidity tier would receive no adjustment under the alternative scoring approach, raising concerns that medically complex patients could be inadequately reimbursed.

Several commenters further expressed that aligning IRF payment methodologies too closely with SNF payment systems could blur distinctions between the two settings and potentially support future site-neutral payment policies. They stated that IRFs serve patients with substantially higher acuity, staffing requirements, and rehabilitation intensity, and that a payment model derived from SNF methodologies may fail to capture those differences. Many commenters therefore recommended that CMS undertake additional interested party engagement, technical expert panels, transparency, impact analyses, and pilot testing before pursuing any major changes to comorbidity scoring or broader IRF payment reform.

Response: We appreciate the comments received regarding the alternative comorbidity scoring methodology. Commenters expressed a range of views, including support for efforts to modernize the IRF comorbidity adjustment methodology and improve the recognition of patient complexity, as well as concerns regarding the methodology's development, transparency, and potential effects on payment accuracy.

Commenters raised questions regarding the applicability of a methodology informed by the SNF setting to the IRF population, the treatment of lower-cost comorbidities, the potential impact on reimbursement for medically complex patients, and the need for additional methodological information and impact analyses. Many commenters recommended further interested party engagement and evaluation before implementation of any significant changes to the comorbidity adjustment methodology.

After consideration of the comments received, we recognize the importance of further evaluating the issues raised by interested parties. We will continue to analyze the alternative comorbidity scoring approach, including its potential impacts on payment accuracy, beneficiary access, and provider behavior, and will consider interested party feedback as we assess potential future refinements to the IRF comorbidity adjustment methodology.

X. Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

A. Background and Statutory Authority

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or Critical Access Hospitals (CAHs) paid by Medicare under the IRF PPS. Section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual increase factor for discharges occurring during a FY for any IRF that does not submit data in accordance with the IRF QRP requirements set forth in subparagraphs (C) and (F) of section 1886(j)(7) of the Act. We have codified our program requirements in our regulations at § 412.634.

We proposed to revise the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. We also solicited public comments on one RFI on future measure concepts for the IRF QRP.

B. General Considerations Used for the Selection of Measures for the IRF QRP

For a detailed discussion of the considerations we use for the selection of IRF QRP quality, resource use, or other measures, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47083 and 47084).

1. Quality Measures Currently Adopted for the IRF QRP

The IRF QRP currently has 15 adopted measures, which are listed in Table 11. For a discussion of the factors we use to evaluate whether a measure should be removed from the IRF QRP, we refer readers to our regulations at § 412.634(b)(2). We refer readers to the CY 2013 OPPS/ASC PPS final rule (77 FR 68502 and 68503) for discussion of our policy that allows any quality measure adopted for use in the IRF QRP to remain in effect until the measure is removed, suspended, or replaced; the FY 2018 IRF PPS final rule (82 FR 36276) which applied this policy to standardized patient assessment data we adopt for the IRF QRP; and the FY 2019 IRF PPS final rule (83 FR 38556 and 38557) for more information on the factors we consider for removing measures and standardized patient assessment data.

TABLE 11: Quality Measures Currently Adopted for the IRF QRP

Short Name	Measure Name & Data Source
Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) Assessment-Based Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health Information to the Provider–Post-Acute Care (PAC)
TOH-Patient	Transfer of Health Information to the Patient–Post-Acute Care (PAC)
DC Function	Discharge Function Score
National Healthcare Safety Network	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

C. IRF QRP Measure Concepts Under Consideration for Future Years—RFI

In the FY 2024 IRF PPS proposed rule (88 FR 21000 through 21003), we included an RFI on a set of principles for selecting and prioritizing IRF QRP measures, identifying measurement gaps and suitable measures for filling these gaps. We refer readers to the FY 2024 IRF PPS final rule (88 FR 51036 and 51037) for a summary of the public comments we received in response to the RFI.

In the FY 2027 IRF PPS proposed rule (91 FR 17195), we sought input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advance care planning. Advance care planning (ACP) is a continuous process that supports people in understanding and communicating their goals, values, and preferences regarding future medical decisions.[16] The Patient Self Determination Act of 1990[17] supports this process by requiring healthcare facilities to inform patients of their rights regarding medical decisions, including advance directives and end of life care.[18] [19] In PAC settings, where patients recover from acute illness, injury, or major procedures, their needs and goals may evolve as their condition changes. Factors such as clinical stability, functional status, therapy tolerance, cognition function, prognosis, and personal preferences can all shift during recovery. Regular reassessment and transparent communication are essential to maintaining person-centered care, while ACP facilitates shared decision-making by documenting patient preferences and ensuring goal-concordant care throughout care transitions.[20] As we review new measure concepts, we would prioritize evidence-based outcome measures that promote person-centered care practices. We sought input on the relevant aspects of ACP and measures appropriate for the IRF setting.

We received public comments on this RFI. The following is a summary of the comments we received.

[16] McMahan, R. D., Tellez, I., & Sudore, R. L. (2021). Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review.*Journal of the American Geriatrics Society, 69*(1), 234–244. *https://doi.org/10.1111/jgs.16801.*

[17] Public Law 101–508, sections 4206, 4751.

[18] *https://www.congress.gov/bill/101st-congress/house-bill/4449.*

[19] *https://www.congress.gov/bill/101st-congress/house-bill/5835.*

[20] McMahan RD, Tellez I, Sudore RL. Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. J Am Geriatr Soc. 2021 Jan;69(1):234–244. doi: 10.1111/jgs.16801. Epub 2020 Sep 7. PMID: 32894787; PMCID: PMC7856112.

Comments: Many commenters expressed support for an ACP measure, emphasizing the importance of discussing patients' goals and preferences as part of the interdisciplinary care provided in the IRF setting. A commenter stated that an ACP measure could improve care consistency, reduce avoidable conflict during transitions, and help ensure that rehabilitation plans reflect what matters most to patients.

Several commenters made recommendations for measure specification and development. A few of these commenters recommended engagement with IRF clinicians, including nurses and recreational therapists, during measure development. A commenter suggested explicitly including caregiver involvement in the measure framework. Another commenter recommended that an ACP measure should be sensitive to the IRF setting's short length of stay, allow flexibility in documentation as required by State law, and include an exception for individuals who refuse. A commenter recommended that CMS focus on plain-language and culturally responsive communication.

A few commenters stated that an ACP measure would be duplicative with other requirements and standards, including the IRF Conditions of Participation, Joint Commission, and CARF accreditation. A commenter recommended that CMS prioritize interoperability and the transfer of ACP information across care settings to reduce unnecessary duplication and support continuity of care.

Several commenters did not support the measure concept of ACP for the IRF QRP. A few commenters expressed concerns about the lack of measure specifications and limited applicability in the IRF setting. Specifically, they stated that patients typically have a short length of stay and are focused on functional improvement rather than long-term care planning. These commenters were concerned that an ACP measure would increase documentation burden without meaningfully improving patient outcomes or differentiating provider performance. Many commenters urged CMS to avoid process measures that may prioritize ''checking a box'' for documentation because the concept would be difficult to tie to a measurable outcome. Other commenters suggested CMS focus on goal-concordant processes rather than documentation completion alone. Another commenter did not believe this information would be valuable to the public.

In addition to comments received on the measure concepts of advance care planning, we also received comments on other future measure concepts. A few commenters recommended transitions of care measures, encouraging improved interoperability between care settings. Another commenter recommended considering patient-reported outcomes and patient-specific goal attainment measures.

Response: We thank all the commenters for responding to this RFI. While we are not responding to specific comments in response to the RFI in this final rule, we may take this feedback into consideration for our future measure development efforts for the IRF QRP.

D. Form, Manner, and Timing of Data Submission Under the IRF QRP

1. Background

We refer readers to the regulatory text at § 412.634(b)(1) for information regarding the current policies for reporting specified data for the IRF QRP.

2. Revise IRF QRP Data Submission Deadlines Beginning With the FY 2029 IRF QRP

a. Background

Sections 1886(j)(7)(E), and 1899B(f) and (g) of the Act require CMS to provide feedback to IRFs and to publicly report their performance on IRF quality measures specified under section 1899B(c)(1) of the Act and resource use and other measures specified under 1899B(d)(1) of the Act. More specifically, section 1899B(f)(1) of the Act requires the Secretary to provide confidential feedback reports to IRFs on their performance on the quality, resource use, and other measures specified under sections 1899B(c)(1) and (d)(1) of the Act. Section 1899B(f)(2) of the Act provides that, to the extent feasible, the Secretary must make these confidential feedback reports available, not less frequently than on a quarterly basis, except in the case of measures reported on an annual basis, in which case confidential feedback reports may be made available annually. Additionally, sections 1886(j)(7)(E) and 1899B(g)(1) of the Act require the Secretary to provide for the public reporting of each IRF's performance on the quality measures, resource use, and other measures specified under section 1899B(c)(1) and (d)(1) of the Act by establishing procedures for making the performance data available to the public. Section 1899B(g)(2) of the Act specifically requires that such procedures must ensure that IRFs can review and submit corrections to the data and other information before it is made public. Section 1886(j)(7)(C) of the Act provides the Secretary 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), we finalized submission deadlines for IRFs to submit their IRF–PAI assessment-based measures data approximately 4.5 months (135 days) after the end of each quarter. We did not receive any comments on the 4.5-month data submission timeframe at that time. We also finalized data submission deadlines for IRF QRP measures that are submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). In the FY 2014 IRF PPS final rule (78 FR 47917), we finalized that for the NHSN Catheter Associated Urinary Tract Infection (CAUTI) and the Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measures, each facility's data must be entered into NHSN no later than 4.5 months after the end of the reporting quarter. We also finalized that the data collection period for the Influenza Vaccination Coverage among Healthcare Personnel (HCP) measure would be October 1 through March 31, with a data submission deadline of May 15th for each influenza season (78 FR 47917).

Public reporting of data collected under quality programs, such as the IRF QRP, is designed to provide consumers and their families with the most current information to empower them to make quality-informed decisions about where to receive their care. We have identified that the current time between when data on measures is submitted to us and when those data are publicly reported (approximately nine months) may be too long to provide the most accurate and up to date information for the public. For example, we have heard from interested parties that the IRF QRP measure results are not useful for their quality improvement efforts due to the aged data and the delay in when they receive these reports.[21]

Currently, the largest contributing factor to the nine-month lag between the end of the data collection period and when measures are publicly reported is the 4.5-month timeframe for data submission. Reducing the data submission timeframe from 4.5 months

[21] McMahan RD, Tellez I, Sudore RL. Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. J Am Geriatr Soc. 2021 Jan;69(1):234–244. doi: 10.1111/jgs.16801. Epub 2020 Sep 7. PMID: 32894787; PMCID: PMC7856112.

to the 15th day of the second month after the end of the calendar quarter (45 days) could reduce this lag by up to three months, resulting in more timely public reporting of data for consumers and increasing the value of publicly reported data. Additionally, this time frame provides IRFs with more recent data in support of their quality improvement activities.

In the FY 2026 IRF PPS proposed rule, we included a request for information (RFI) on reducing the assessment data submission deadline from 4.5 months to 45 days (90 FR 18554). We refer readers to the FY 2026 IRF PPS final rule (90 FR 37712) for a full summary of the public comments received.

b. Revision of the IRF QRP Assessment Data Submission Deadline

Beginning with the FY 2029 IRF QRP, we proposed that IRFs must complete their data submissions and make corrections to their IRF–PAI assessment data where necessary no later than the 15th day of the second month after the end of the calendar quarter. However, if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day. We proposed that IRFs will follow the deadlines presented in Table 12 for the FY 2029 IRF QRP. We also proposed that similar calendar year data submission deadlines would apply to future years' payment determinations.

TABLE 12: Data Collection Timeframe and Data Submission Deadlines for IRF--PAI Assessment Data Affecting the FY 2029 Payment Determination

Calendar Year (CY) Quarter	Data collection timeframe	Final data submission deadlines for FY 2029 payment determination*
CY 2027 Quarter 1	January 1–March 31, 2027	May 17, 2027
CY 2027 Quarter 2	April 1–June 30, 2027	August 16, 2027
CY 2027 Quarter 3	July 1–September 30, 2027	November 15, 2027
CY 2027 Quarter 4	October 1–December 31, 2027	February 15, 2028

* Data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

We believe that requiring IRFs to submit IRF–PAI assessment data by the 15th day of the second month after the end of the calendar quarter is reasonable. We conducted an analysis on the potential impact of reducing the timeframe by determining how many assessments are currently being submitted by this deadline, which is approximately within 45 days of the end of the quarter. Using 2024 data, we identified that 99.08 percent of all IRF–PAI assessments were submitted to CMS within a 45-day timeframe. Of the remaining 0.92 percent submitted beyond 45 days, 0.20 percent were submitted after the current 4.5-month data submission deadline and would not be further impacted by a change in the data submission deadline. Therefore, only 0.72 percent of IRF–PAI assessments would be impacted by changing the data submission deadline from 4.5 months to require data submission by the 15th day of the second month after the end of the calendar quarter.

c. Revision of the CDC NHSN Data Submission Deadlines

Beginning with the FY 2029 IRF QRP, we proposed that IRFs must complete their data submissions and make corrections to their CDC NHSN data where necessary no later than the 15th day of the second month after the end of the calendar quarter. However, if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day. We proposed that IRFs would follow the deadlines presented in Table 13 for the FY 2029 IRF QRP. We proposed that similar calendar year data submission deadlines would apply to future years' payment determinations.

TABLE 13: Proposed Data Collection Timeframe and Data Submission Deadlines for CDC NHSN IRF QRP Measures Affecting the FY 2029 Payment Determination

Measure	Data collection timeframe	Final data submission deadlines for FY 2029 payment determination*
CAUTI CDI	January 1–March 31, 2027	May 17, 2027
	April 1–June 30, 2027	August 16, 2027
	July 1–September 30, 2027	November 15, 2027
	October 1–December 31, 2027	February 15, 2028
Influenza Vaccination Coverage among HCP	October 1, 2027—March 31, 2028	May 15, 2028

* Data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

We believe that requiring IRFs to submit CDC NHSN data by the 15th day of the second month after the end of the calendar quarter is a reasonable amount of time. In the FY 2014 IRF PPS final rule (78 FR 47917), we noted that the CDC recommends that a facility report Healthcare Acquired Infection (HAI) events such as CAUTI as close to the time of the event as possible, and certainly within 30 days after the event. We note that there would be no change in the data submission deadline for the Influenza Vaccination Coverage among HCP measure, as the previously finalized data submission date is May 15th for each influenza season.

We conducted an analysis on the potential impact of reducing the timeframe by determining how many IRFs are currently reporting data by this deadline, which is approximately within 45 days of the end of the quarter. Using FY 2025 data, we identified that 88.5 percent of all IRFs submitted CDC NHSN data within a 45-day timeframe.

On these bases, we believe requiring IRFs to complete their IRF QRP (IRF–PAI and CDC NHSN) data submissions, and make corrections where necessary, no later than the 15th day of the second month after the end of the calendar quarter (beginning with the FY 2029 IRF QRP) would improve the timeliness of public reporting by three months, which is beneficial to both consumers and IRFs, with no change in burden to IRFs.

We invited comment on this proposal. The following is a summary of the public comments received and our responses.

Comment: We received many comments in support of the proposal to revise the data submission deadline, stating that timelier public reporting would give patients and consumers access to more current IRF quality data when making healthcare decisions. Another commenter also believed that it would allow administrative and clinical feedback to be returned to IRFs to improve care quality. A commenter agreed with the proposal, citing that their providers already submit data within 45 days.

Response: We thank commenters for their support and agree that this proposal would give patients and consumers more timely access to quality data and give IRFs better data for quality improvement.

Comment: We received many comments in support of the goal to shorten the data submission deadline, but with a different timeframe to better allow for complete and accurate data. The majority of commenters advocated for longer submission windows, ranging from 60 to 100+ days to support validation and correction of submission errors. Additionally, many commenters recommended a consistent deadline that will not shift due to weekends or federal holidays, to allow systems to be automated. Another commenter recommended requiring submission by the ''last business day of the month,'' rather than the ''15th day of the month.''

Response: We considered the recommendations for alternative data submission deadlines. We disagree with the recommendations to adopt an alternate deadline, such as 60 or 90 days after the end of the quarter, because that would not allow us to close the 9-month lag between the end of the data collection period and when measures are publicly reported. CMS updates the publicly reported data on the *Medicare.gov* Compare tool on a quarterly basis (March, June, September, and December). As finalized in the FY 2017 IRF PPS final rule (81 FR 52129), IRFs have 30 days to preview their quality measure results and request CMS review of the data should they believe the quality measure results to be inaccurate, prior to the data being publicly reported. The updated 45-day data submission deadline allows data to be publicly reported one quarter earlier while still allowing time for CMS to calculate measure results, provide confidential feedback reports, and give IRFs 30 days to preview and correct their data. Adopting a longer timeline would negate the primary benefit of this policy change, which is to provide more timely data to consumers and IRFs. Missing the cutoff for one refresh means data is held until the next refresh, adding approximately 3 additional months of delay.

For example, under the proposed 45-day deadline, data for Q1 CY 2027 submitted on May 17, 2027 could be published on the Compare tool on *Medicare.gov*in the September 2027 refresh. However, using the commenters' suggested 90-day deadline, data would be submitted around June 29, 2027; for a 60-day deadline, data would be submitted around May 31, 2027. After allotting time for measure calculation, the 30-day provider preview period, and CMS validation efforts, data submitted under either of these recommended deadlines would not be published until the December 2027 Compare tool refresh. This is the same 9-month lag that exists under our current data submission deadline. By contrast, the proposed 45-day deadline allows Q1 2027 data to be published approximately three months earlier than under the current or commenter-suggested timelines, meaningfully improving the timeliness of information available to consumers and providers.

With regard to comments recommending a deadline that will not

shift due to weekends or federal holidays, we wish to clarify that this is not a new requirement, as our current policy already shifts the deadline for weekends and federal holidays. We have previously heard from interested parties that flexibility around these dates is appreciated, since administrative and support staff may not be in the IRF on those days to submit data. We also note that providers can submit the data at any time during the data submission timeframe. They do not need to alter their workflows if the deadline is moved due to a weekend or holiday, if they wish to submit data earlier, especially if they have automated workflows.

Comment: We received a few comments in support of the proposal's goal of a shorter submission deadline and timelier public reporting, but with concerns about the impact on IRF information technology (IT) infrastructure and workflow and on IRF QRP data. Some commenters were concerned that IRFs, particularly small or rural IRFs, may need to change existing workflows and update their IT systems, which may be costly. A few commenters were concerned that the proposed timeline may undermine data completeness and accuracy by reducing time for IRFs to complete internal reviews, ensure proper coding, or align with electronic health records before submission. A commenter was concerned that this reduction could result in misleading or inconsistent information on the Compare tool on *Medicare.gov.*

Response: We acknowledge the commenters' concerns about IT workflow and infrastructure, especially for small or rural IRFs. However, we are not adding any new requirements or additional data submission for IRFs but instead proposed to shift the time frame for this existing work. By proposing to implement this policy beginning in January 2027, we believe that we are giving IRFs enough time to make any updates to IT systems and workflow operations. Regarding concerns about data completeness and accuracy, we believe IRFs have time to shift their staffing and processes to ensure they validate data and make any corrections needed by the new deadline. In addition, our internal analysis (91 FR 17221 and 17222) showed that over 99 percent of IRFs already submit IRF–PAI assessment and CDC NHSN data within 45 days, which suggests that data submission within this timeframe is feasible. Because IRF–PAI assessments are tied to payment, providers are likely to submit assessments close to the date of service.

We disagree with the commenter's concerns that this proposal would result in misleading or inconsistent information being publicly reported. This proposal would allow for more timely data to be reported on the Compare tool on Medicare.gov, and we believe that IRFs will have enough time to implement workflow updates to allow them to complete reviews and check data prior to the updated deadline. We would also like to note that this proposal will benefit IRFs by allowing them to have access to more timely data for quality improvement efforts.

Comment: Several commenters expressed concerns about staffing. A few commenters expressed concerns that the proposal would increase administrative burden and strain facilities that continue to experience significant workforce shortages and staffing challenges, requiring facilities to divert clinical personnel away from direct patient care. A commenter was also concerned that the proposal would reduce flexibility for facilities that experience staffing shortages.

Response: We appreciate the commenters' concerns about staffing and burden challenges. However, we are not adding any new reporting requirements to the IRF QRP and do not believe this proposal would require IRFs to divert personnel away from direct patient care. This proposal does not change the expectations for assessing patients; rather, this proposal would shift the existing data submission workflow from 4.5 months after each quarterly data collection period to the 15th day of the second month after the end of the calendar quarter. As described in the proposed rule (91 FR 17221), our internal analysis showed that most IRFs already submit assessment and CDC NHSN data within 45 days.

Comment: Some commenters were opposed to revising the data submission deadlines for the CDC NHSN measures. A commenter stated that reducing the CAUTI and CDI reporting deadlines could pose difficulties for infection preventionists, particularly if their facility has a long backlog of reports or if their infection prevention team is understaffed. Other commenters were concerned about discordant reporting timelines for the same surveillance infrastructure and reporting teams since a new deadline would no longer align with CAUTI and CDI reporting requirements for the Hospital Inpatient Quality Reporting (IQR) Program.

Response: We appreciate concerns about the demands on infection prevention teams. However, we do not believe that this proposal changes CDC's underlying guidance on infection reporting.

While there may be variation in the CDC NHSN data submission deadline for purposes of fulfilling CMS quality reporting requirements, CDC NHSN requires data submission for CAUTI [22] and CDI [23] on a monthly basis and strongly encourages healthcare facilities to enter each month's data within 30 days of the end of the month in which it is collected. In the FY 2014 IRF PPS final rule (78 FR 47917), we noted that the CDC recommends that a facility report Healthcare Acquired Infection (HAI) events such as CAUTI as close to the time of the event as possible, and certainly within 30 days after the event. The IRF QRP proposal aims to align the reporting requirements with other post-acute care programs, including recent proposals for the LTCH and SNF QRPs, and to reach our goal of providing more timely data to consumers and IRFs.

Comment: We received several comments with recommendations for the implementation of this policy. A few commenters encouraged CMS to conduct stakeholder engagement and pilot testing prior to implementing this policy. Another commenter encouraged CMS to conduct impact analysis with a representative sample of IRFs. Several commenters supported the proposal but recommended a phased approach to implementation to evaluate workflows and address operational challenges.

A few commenters had recommendations about improving the internet Quality Improvement & Evaluation System (iQIES) and NHSN reporting infrastructure, including improved transparency and real-time feedback mechanisms. A commenter recommended that CMS provide enhanced technical assistance to IRFs to ensure successful transition to the new deadlines. Another commenter recommended targeted outreach to IRFs prior to the data submission deadline.

Response: We appreciate commenters' input and recommendations for implementation of this proposal. CMS conducted internal analysis before proposing the change to the deadline

[22] Operational Guidance for Inpatient Rehabilitation Facilities to Report Catheter-Associated Urinary Tract Infection (CAUTI) Data to CDC's NHSN for the Purpose of Fulfilling CMS's Quality Reporting Requirements. *https://www.cdc.gov/nhsn/pdfs/cms/irfs/IRF-CAUTI-Guidance-508.pdf.*

[23] Operational Guidance for Inpatient Rehabilitation Facilities to Report Clostridioides difficile Infection (CDI) Laboratory-Identified (LabID) Event Data to CDC's NHSN for the Purpose of Fulfilling CMS's Quality Reporting Program Requirements. *https://www.cdc.gov/nhsn/pdfs/cms/irfs/irf-cdi-op-guidance.pdf.*

and is confident that IRFs will succeed in meeting the new timeline. We believe pilot testing or a phased implementation approach would add operational complexity, as providers would have to update workflows and modify staffing multiple times. We will continue to monitor data submission compliance rates as part of program monitoring.

We would like to note that we currently conduct general outreach (such as email communications) and targeted outreach to individual IRFs about upcoming data submission deadlines. We also provide guidance and technical manuals, data submission deadline documents, and training resources. We intend to make timely updates to our outreach processes, manuals, data submission deadline documents and training resources. Regarding technical assistance and support, we list resources and several help desks on our website at *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-help* and *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-faqs.* We plan to continue our routine program monitoring activities to evaluate impacts of this policy on data submission and compliance with QRP requirements.

Regarding recommendations about improving the internet Quality Improvement & Evaluation System (iQIES), we refer commenters to the iQIES Idea Portal,[24] which allows the public to submit, comment, vote, and follow ideas on how to improve or enhance iQIES. For recommendations for NHSN reporting infrastructure, we encourage IRFs to reach out to the CDC NHSN help desk directly at *nhsn@cdc.gov.*

Comment: A couple of commenters supported the proposal but recommended allowing IRFs to request reasonable extensions to submit data due to unforeseen circumstances and exercise enforcement discretion for any reasons for the first year. Another commenter expressed concerns about system outages and IT issues that may increase the risk of incomplete or invalidated submissions, especially close to the end of the quarter.

Response: We appreciate the commenters' requests for reasonable extensions due to unforeseen circumstances. Regarding the concerns about system outages and IT issues near the end of the quarter, we wish to note that this concern is not new. IRFs are encouraged to be prepared for EHR and system outages. CMS currently provides IRFs with the opportunity to request an exception or extension from the program's reporting requirements in the event they were unable to submit quality data due to extraordinary circumstances beyond their control. IRFs affected by a natural or man-made disaster or other extraordinary circumstances may request an exception and extension using instructions found on the IRF QRP website: *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-reconsideration-and-exception-extension.*

Comment: We received a few comments opposed to the proposal to revise the data submission deadlines. A commenter was opposed to the proposal, citing administrative strain. Other commenters were opposed to the proposed revised deadlines, stating that IRFs require a minimum of 60 days after quarter close to complete data abstraction, validation, and internal quality checks. These commenters stated concerns including staffing variability, NHSN ticket resolution timelines, technical and system challenges, and increased administrative burden. Another commenter recommended that CMS implement a grace period for correcting technical issues with data.

Response: We appreciate the concerns about technical challenges, staffing variability, and administrative strain and burden. However, we note that we are not adding any new requirements or additional data submission for IRFs but rather proposed to shift the time frame for completing the existing requirements. By proposing to implement this policy beginning in January 2027, we believe that we are giving IRFs enough time to make any updates to IT systems, workflow operations, and staffing to allow them to validate data and make any corrections needed by the new deadline. We disagree with the commenter's statement that IRFs require a minimum of 60 days after quarter close for data abstraction, validation, and quality checks. To the extent commenters are referring to validation and quality checks being completed by third party vendors, third-party validation and quality checks are not a requirement for IRF QRP data. In addition, data submitted to CMS are available for IRFs to review and validate within the proposed data submission time frame, via the data submission portals in iQIES and NHSN. We also expect data validation and quality checks to be complete with the initial data submission, with better proximity to the patient. IRFs have 30 days to preview their quality measure results and request CMS review of the data should they believe the quality measure results to be inaccurate, once the measure has been calculated.

We also note that delaying the data submission deadline would not allow us to reduce the 9-month lag between the end of the data collection period and when measures are publicly reported. With regard to comments about a grace period, we do not believe this is necessary since our internal analysis (91 FR 17221 and 17222) showed that over 99 percent of IRFs already submit IRF–PAI assessment and CDC NHSN data within 45 days. Allowing a grace period or a longer time frame for data submission would not allow us to reach our goal of providing more timely data to consumers and IRFs.

In response to the comments about NHSN ticket resolution timelines and system challenges, we encourage IRFs to reach out to the CDC NHSN help desk directly at *nhsn@cdc.gov.*

Comment: We received several comments that were outside the scope of the FY 2027 IRF PPS proposed rule. Specifically, we received comments recommending the removal of data collection requirements in the IRF QRP.

Response: We thank the commenters for bringing these issues to our attention and may take these comments into consideration for potential policy refinements.

After consideration of public comments, we are finalizing our proposal to require IRFs to submit their data and make corrections to their IRF–PAI assessment and CDC NHSN data where necessary no later than the 15th day of the second month after the end of the calendar quarter beginning with the FY 2029 IRF QRP.

E. Policies Regarding Public Display of Measure Data for the IRF QRP

We did not propose any new policies regarding the public display of measure data in the proposed rule. For a more detailed discussion about our policies regarding public display of IRF QRP measure data and procedures for the opportunity to review and correct data and information, we refer readers to the FY 2017 IRF PPS final rule (81 FR 52128 through 52131).

[24] More information can be found at: *https://qtso.cms.gov/system/files/qtso/Idea%20Portal%20User%20Manual%20and%20FAQs%20FINAL%20v.2.0.pdf.*

XI. Change to the DMEPOS Competitive Bidding Program (CBP)

A. Bid Surety Bond Amount

1. Background

Section 522(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114–10) (MACRA) added a requirement under section 1847(a)(1)(G) of the Act requiring bidding entities to obtain a bid surety bond for each competitive acquisition area in which the entity submits the bid in a form specified by the Secretary and in an amount not less than $50,000 and not more than $100,000. CMS implemented this requirement as part of the final rule titled, ''Medicare Program; End-Stage Renal Disease Prospective Payment System, Coverage and Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program Bid Surety Bonds, State Licensure and Appeals Process for Breach of Contract Actions, Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program and Fee Schedule Adjustments, Access to Care Issues for Durable Medical Equipment; and the Comprehensive End-Stage Renal Disease Care Model,'' published in the **Federal Register** on November 4, 2016 (81 FR 77834) (hereinafter referred to as the ''2016 ESRD PPS & DMEPOS final rule''). Pursuant to the CY 2016 ESRD PPS and DMEPOS final rule, and as codified at 42 CFR 414.412(g), a bidding entity may not submit a bid(s) and be awarded a contract for a competition unless it obtains, in the amount of $50,000, a bid surety bond for the competitive bidding area (CBA) (as defined at 42 CFR 414.402) from an authorized surety on the Department of the Treasury's Listing of Certified Companies and provides proof of having obtained the bond by submitting a copy to CMS by the deadline for bid submission. These requirements first applied to Round 2021, the first round of competitive bidding following the passage of MACRA.

Section 1847(a)(1)(H)(i) of the Act provides that in the event that a bidding entity is offered a contract for any product category for a CBA, and its composite bid for such product category and area is at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amount (SPA) for the product category and CBA, and the entity does not accept the contract offered, the bid surety bond for the applicable CBA will be forfeited and the Secretary will collect on the bid surety bond. As implemented in regulation at § 414.412(g) (redesignated from § 414.412(h) (see 83 FR 57025)), CMS will collect on the bid surety bond via Electronic Funds Transfer from the respective bonding company. In instances where a bidding entity does not meet the bid surety bond forfeiture conditions for any product category for a CBA as specified in section 1847(a)(1)(H)(i) of the Act, section 1847(a)(1)(H)(ii) of the Act requires that the bid surety bond liability submitted by the entity for the CBA will be returned to the bidding entity within 90 days of the public announcement of the contract suppliers for such area.

The bid surety bond requirement deters bidding entities from submitting a low, disingenuous bid amount in order to increase the probability that they will be offered a DMEPOS contract, as they will forfeit the bid surety bond if the bid is at or below the median composite bid rate and the bidding entity does not accept the offered contract.

2. Current Issues

In the Calendar Year (CY) 2026 Home Health Prospective Payment System (PPS) Final Rule (see 90 FR 55342–55620) published in the **Federal Register** on December 2, 2025, CMS established the Remote Item Delivery (RID) Competitive Bidding Program (CBP). The term ''remote item delivery competitive bidding program'' is defined under § 414.402 to mean a competitive bidding program wherein contract suppliers are responsible for furnishing remote item delivery items under a product category to all Medicare beneficiaries regardless of where they live in the CBA. The CBA could be one nationwide CBA that includes all areas (all States, territories, and the District of Columbia) or a CBA covering a specific region of the country.

The term ''remote item delivery item'' is defined under § 414.402 to mean an item falling under a remote item delivery competitive bidding program that may be shipped or delivered to a beneficiary's home, regardless of the method of delivery, or picked up at a local pharmacy or supplier storefront if the beneficiary or caregiver for the beneficiary chooses to pick the item up in person.

In the CY 2026 Home Health PPS final rule (90 FR 55342–55620), we stated that we plan to implement remote item delivery (RID) competitive bidding programs (CBPs) for certain items designated under the DMEPOS CBP, and further explained that competitions for RID items may involve larger competitive bidding areas (CBAs), including nationwide CBAs. To discourage DMEPOS suppliers from submitting non-serious or disingenuous bids and to ensure genuine commitment from suppliers awarded contracts under a RID CBP, in the FY 2027 IRF PPS proposed rule (91 FR 17195 through 17230), we proposed requiring one bid surety bond at the maximum allowable amount of $100,000 for any and all bids submitted by a bidding entity for RID CBAs in a round of the DMEPOS CBP. This maximum bond amount is justified because a RID CBA, even when structured as a regional competition, can span multiple States and serve beneficiaries across a vast geographic footprint, far exceeding the scope of a traditional CBA, which is typically confined to a single metropolitan statistical area (MSA) within one state. The significantly greater scale, complexity, and beneficiary population associated with a RID CBA warrant the highest available level of financial commitment from bidders. This higher amount would also provide a stronger incentive for suppliers bidding on a RID CBA to submit bona fide bids and accept contract offers, thereby supporting the core objective of the DMEPOS CBP to reduce the amount Medicare pays for competitively bid DMEPOS and bring payment amounts more in line with those of a competitive market. A higher bid surety bond amount is further supported by section 1847(b)(4)(A) of the Act, which directs CMS to consider whether bidders can furnish sufficient items or services to meet the anticipated needs of individuals within the contract's geographic area on a timely basis—a standard that is particularly demanding given the broad, multi-state reach of a RID CBA.

We proposed to maintain the bid surety bond amount of $50,000 for all non-RID competitions.

Rather than implementing hundreds of separate local CBPs and CBAs—which would impose unnecessary administrative burden on both the bidding program and suppliers—we believe the most practical approach is to consolidate RID competitions into one nationwide RID CBP or several large regional RID CBPs, covering all areas where a beneficiary resides or receives covered items under the applicable product categories, with limited exceptions as described in the CY 2026 Home Health PPS Final Rule (90 FR 29254). This approach is consistent with longstanding Federal guidance from a September 2004 GAO report (GAO–04–765), which recommended that CMS

exploremail delivery as a viable competitive bidding strategy for items provided directly to beneficiaries in the home, and noted that the Medicare Modernization Act (MMA) authorizes CMS to designate the entire country as a single competitive area for select items. The GAO further emphasized that a consolidated nationwide approach would allow CMS to implement competitive bidding more quickly and efficiently than a piecemeal strategy, enabling companies with nationwidemail-order capability to compete for Medicare beneficiaries' business. The maximum bond requirement, combined with this consolidated RID CBP framework, promotes accountability, reduces administrative complexity, and ensures that only capable and committed suppliers participate in RID competitive bidding.

B. Provisions of the Regulation

We proposed that for future rounds of the DMEPOS CBP, the bid surety bond amount in § 414.412(g)(2)(i)(H) would remain at $50,000, and we proposed to revise § 412(g)(2)(i)(H) to no longer use the term ''bid bond value'' and instead use the more common term ''bid surety bond amount.'' However, to submit a bid(s) and be awarded a contract for a RID CBP, we proposed under § 414.412(g)(2)(iii) that the bidding entity must obtain a bid surety bond of $100,000. Additionally, we proposed under § 414.412(g)(2)(iii) that if submitting bids for multiple competitions under a RID CBP, only one bid surety bond is required, regardless of whether the RID CBP competitions have different CBAs. We solicited comments on these proposals. The following is a summary of the public comment received and our response.

Comment: We received a comment in support of the proposal to increase the bid surety bond for RID CBP from $50,000 to $100,000. The commenter noted how, under this proposal, a single $100,000 bond would cover all bids a supplier submits in the RID CBP. Considering the upcoming implementation of a nationwide RID CBP for all product categories in the next round of the DMEPOS CBP, the commenter expressed support for the increase, believing it be reasonable and believing that the higher financial threshold will ensure bidder accountability reflecting the larger geographic scale of a nationwide delivery area. The commenter stated that this will only be true if the RID CBP is larger than a metropolitan statistical area, such as State/regional/nationwide. The commenter also noted how a bid bond plays an important role in deterring bad-faith bidding and protecting the Medicare Trust Fund.

Response: We thank the commenter for their feedback and support.

After consideration of the public comments, we are finalizing as proposed that, under § 414.412(g)(2)(iii), to submit a bid(s) and be awarded a contract for a RID CBP, the bidding entity must obtain a bid surety bond of $100,000; that, under § 414.412(g)(2)(iii), if submitting bids for multiple competitions under a RID CBP, only one bid surety bond is required, regardless of whether the RID CBP competitions have different CBAs; and that for non-RID competitions in future rounds of the DMEPOS CBP, the bid surety bond amount at § 414.412(g)(2)(i)(H) will remain at $50,000. We are also finalizing as proposed to revise § 412(g)(2)(i)(H) to no longer use the term ''bid bond value'' and instead use the more common term ''bid surety bond amount.''

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comments on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs for Proposed Updates Related to the IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2-percentage point reduction to its otherwise applicable annual increase factor for that fiscal year. We estimate that the burden associated with the IRF QRP is the time and effort associated with complying with the requirements of the IRF QRP. The IRF–PAI, in its current form, has been approved under OMB control number 0938–0842 (expiration 10/31/2027). In section X.D.2 of the proposed rule, we proposed to revise the data submission deadlines beginning with the FY 2029 IRF QRP. This requirement will not result in additional collection burden for the IRF QRP or revisions to the currently approved IRF–PAI.

We did not receive public comments on this provision.

If you comment on this information collection, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, CMS–1845–F.

Fax: (202) 395–6974; or

Email: OIRA_submission@omb.eop.gov.

XIII. Regulatory Impact Analysis

A. Statement of Need

This final rule updates the IRF prospective payment rates for FY 2027 as required under section 1886(j)(3)(C) of the Act and in accordance with section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before August 1 before each FY, the classification and weighting factors for CMGs used under the IRF PPS for such FY and a description of the methodology and data used in computing the prospective payment rates under the IRF PPS for that FY. This final rule will also implement section 1886(j)(3)(C) of the Act, which requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2012 and subsequent years.

Furthermore, this final rule adopts policy changes to the IRF QRP under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

We estimated the total impact of the policy updates described in this final rule by comparing the estimated payments in FY 2027 with those in FY 2026. This analysis results in an estimated $340 million increase for FY 2027 IRF PPS payments. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) of E.O. 12866 because it will have an effect on the economy of $100 million or more in any 1 year. Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

C. Detailed Economic Analysis

We have estimated the impact of the final rule. This final rule updates the IRF PPS rates contained in the FY 2026 IRF PPS final rule (90 FR 37678). Specifically, this final rule updates the CMG relative weights and ALOS values, the wage index, and the outlier threshold for high-cost cases. This final rule would apply a productivity adjustment to the FY 2027 IRF market basket percentage increase in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.

1. Impact on IRFs

We estimate that the impact of the changes and updates described in this final rule will be a net estimated increase of $340 million in payments to IRFs for FY 2027. The impact analysis in Table 14 of this final rule represents the projected effects of the updates to IRF PPS payments for FY 2027 compared with the estimated IRF PPS payments in FY 2026. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2027, we are implementing the standard annual revisions described in this final rule (for example, the update to the wage index and market basket percentage increase used to adjust the Federal rates). We are also reducing the FY 2027 IRF market basket percentage increase by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. We estimate that the total increase in payments to IRFs in FY 2027, relative to FY 2026, will be approximately $340 million.

This estimate is derived from the application of the FY 2027 IRF market basket percentage increase, reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, which yields an estimated increase in aggregate payments to IRFs of $285 million. In addition, there is an estimated $50 million increase in aggregate payments to IRFs due to the update to the outlier threshold amount. We estimate that these updates would result in a net increase in estimated payments of $340 million from FY 2026 to FY 2027.

The effects of the updates that impact IRF PPS payment rates are shown in Table 14. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the update to the outlier threshold amount, from approximately 2.6 percent to 3.0 percent of total estimated payments for FY 2027, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the 2021-based IRF market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and (j)(3)(C) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act, accounting for the permanent cap on wage index decreases when applicable.
- The effects of the budget-neutral changes to the CMG relative weights and ALOS values under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2027 payment changes relative to the estimated FY 2026 payments.

2. Description of Table 14

Table 14 shows the overall impact on the 1,178 IRFs included in the analysis. The next 12 rows of Table 14 contain IRFs categorized according to their geographic location, designated as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 1,037 IRFs located in urban areas included in our analysis. Among these, there are 647 IRF units of hospitals located in urban areas and 390 freestanding IRF hospitals located in urban areas. There are 141 IRFs located in rural areas included in our analysis. Among these, there are 127 IRF units of hospitals located in rural areas and 14 freestanding IRF hospitals located in rural areas. There are 540 for-profit IRFs. Among these, there are 501 IRFs in urban areas and 39 IRFs in rural areas. There are 543 non-profit IRFs. Among these, there are 459 urban IRFs and 84 rural IRFs. There are 95 government-owned IRFs. Among these, there are 77 urban IRFs and 18 rural IRFs.

The remaining four parts of Table 14 show IRFs grouped by geographic location within a region, by teaching status, and by DSH patient percentage (PP). First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs

located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this final rule to the facility categories listed are shown in the columns of Table 14. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2027 analysis file.
- Column (3) shows the number of cases in each category in our FY 2027 analysis file.
- Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the FY 2027 update to the IRF labor-related share, wage index with the 5-percent cap on wage index decreases when applicable, and final year of the 3-year phase-out of the rural adjustment finalized in the FY 2026 IRF PPS final rule, in a budget-neutral manner.
- Column (6) shows the estimated effect of the update to the CMG relative weights and ALOS values, in a budget-neutral manner.
- Column (7) compares our estimates of the payments per discharge, incorporating all of the policies reflected in this final rule for FY 2027 to our estimated payments per discharge in FY 2026.

The average estimated increase in payments for all IRFs is approximately 2.7 percent. This estimated net increase includes the effects of the IRF market basket update for FY 2027 of 2.3 percent, which is based on an IRF market basket percentage increase of 3.2 percent, less a 0.9 percentage point productivity adjustment, as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.4 percent overall increase in estimated IRF outlier payments from the update to the outlier threshold amount. Since we are updating the IRF wage index, labor-related share and the CMG relative weights in a budget-neutral manner, we estimate there is no expected impact to total estimated IRF payments in aggregate from these changes. However, as described in more detail in each section, we estimate there will be expected impacts to the estimated distribution of payments among providers.

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TABLE 14: IRF Impact for FY 2027 (Columns 4 through 7 in Percentages)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2027 Labor-Related Share & FY 2027 Wage Index	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,178	475,801	0.4	0.0	0.0	2.7
Urban unit	647	149,666	0.9	0.1	0.0	3.4
Rural unit	127	16,835	0.7	0.4	-0.1	3.3
Urban hospital	390	300,932	0.1	-0.1	0.0	2.3
Rural hospital	14	8,368	0.1	0.8	-0.1	3.1
Urban For-Profit	501	300,739	0.2	-0.1	0.0	2.4
Rural For-Profit	39	12,217	0.3	0.6	-0.1	3.2
Urban Non-Profit	459	131,362	0.8	0.0	0.0	3.1
Rural Non-Profit	84	11,062	0.7	0.4	-0.1	3.3
Urban Government	77	18,497	0.9	0.5	0.0	3.8
Rural Government	18	1,924	0.6	0.5	-0.1	3.4
Urban	1,037	450,598	0.4	0.0	0.0	2.7
Rural	141	25,203	0.5	0.5	-0.1	3.2
Urban by region						
Urban New England	31	17,286	0.3	0.3	0.0	2.9
Urban Middle Atlantic	111	43,867	0.6	0.4	0.0	3.3
Urban South Atlantic	198	110,174	0.3	0.0	0.0	2.6
Urban East North Central	165	53,016	0.4	-0.2	0.0	2.5
Urban East South Central	55	30,724	0.2	-0.7	0.0	1.7
Urban West North Central	79	27,000	0.4	0.7	0.0	3.4
Urban West South Central	214	99,449	0.2	-0.3	0.0	2.2
Urban Mountain	85	39,741	0.3	-0.1	0.0	2.5
Urban Pacific	99	29,341	1.1	0.3	0.1	3.8
Rural by region						
Rural New England	5	1,043	0.6	2.5	0.0	5.5
Rural Middle Atlantic	11	1,437	0.5	0.5	-0.2	3.1
Rural South Atlantic	16	6,737	0.1	1.1	-0.2	3.4
Rural East North Central	22	3,010	0.7	0.7	-0.1	3.7
Rural East South Central	18	3,174	0.4	0.5	0.0	3.2
Rural West North Central	18	2,351	0.9	0.3	-0.1	3.5
Rural West South Central	44	7,084	0.6	-0.3	-0.1	2.5
Rural Mountain	5	254	1.3	-0.7	0.0	2.9
Rural Pacific	2	113	1.7	-0.7	-0.3	3.0
Teaching status						
Non-teaching	1,074	422,778	0.4	-0.1	0.0	2.6
Resident to ADC less than 10%	63	38,803	0.5	0.5	0.0	3.4
Resident to ADC 10%-19%	31	11,878	1.0	0.7	0.1	4.2
Resident to ADC greater than 19%	10	2,342	0.6	0.3	0.0	3.3

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2027 Labor-Related Share & FY 2027 Wage Index	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	42	8,467	0.8	0.0	0.0	3.1
DSH PP <5%	234	132,788	0.2	-0.1	0.0	2.3
DSH PP 5%-10%	286	121,549	0.3	0.0	0.0	2.5
DSH PP 10%-20%	372	146,003	0.5	0.2	0.0	3.0
DSH PP greater than 20%	244	66,994	0.7	-0.2	0.1	2.9

[1]This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF market basket update for FY 2027 of 3.2 percent, reduced by 0.9 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

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3. Impact of the Update to the Outlier Threshold Amount

The estimated effects of the update to the outlier threshold adjustment from FY 2026 to FY 2027 are presented in column 4 of Table 14.

For the FY 2027 proposed rule, we used preliminary FY 2025 IRF claims data and based on that preliminary analysis, we estimated that IRF outlier payments as a percentage of total estimated IRF payments would be 2.6 percent in FY 2026. Thus, we are adjusting the outlier threshold amount in this final rule from $10,141 in FY 2026 to $8,857 in FY 2027 to maintain total estimated outlier payments equal to 3 percent of total estimated payments in FY 2027. The estimated change in total IRF payments for FY 2027, therefore, includes an approximate 0.4 percentage point increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.6 percent to 3.0 percent. The impact of this update to the outlier threshold amount (as shown in column 4 of Table 14) is to increase estimated overall payments to IRFs by 0.4 percentage point.

4. Impact of the Wage Index, Labor-Related Share, and Wage Index Cap

In column 5 of Table 14, we present the effects of the budget-neutral update of the wage index and labor-related share, taking into account the permanent 5-percent cap on wage index decreases when applicable. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this final rule, the FY 2027 labor-related share is 74.3 percent, 0.1 percentage point lower than the labor-related share for FY 2026.

In the aggregate, since these final updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we estimate that these changes will have distributional effects. For example, we estimate that the largest increase in payments from the update to the wage index and labor-related share to be 2.5 percent for rural IRFs in the New England region, contributing to the largest overall estimated payment increase of 5.5 percent for those providers. We estimate the largest decrease in payments from the update to the wage index and labor-related share to be a 0.7 percent decrease for urban IRFs in the East South Central region and for rural IRFs in the Rural Mountain and Rural Pacific regions.

5. Impact of the Update to the CMG Relative Weights and ALOS Values

In column 6 of Table 14, we present the effects of the budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these final updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects between −0.3 percent to 0.1 percent.

6. Effects of Requirements for the IRF QRP

In accordance with section 1886(j)(7)(A) of the Act, the Secretary must reduce by 2 percentage points the annual market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section X.A. of the proposed rule, we discussed the method for applying the 2-percentage points reduction to IRFs that fail to meet the IRF QRP requirements. In section X.D.2. of the proposed rule, we proposed to revise the data submission deadlines beginning with the FY 2029 IRF QRP. This requirement will not result in additional collection burden for the IRF QRP.

7. DMEPOS Competitive Bidding Program

This rule changes the DMEPOS CBP to further enhance its effectiveness in achieving the objectives of the program as mandated by section 1847(a) of the Act. Specially, we are increasing the bid surety bond amount from $50,000 to $100,000 for any and all bids submitted by a bidding entity for remote item delivery (RID) competitive bidding program areas (CBAs) in a round of the DMEPOS CBP while maintaining $50,000 for all other CBAs. The primary factor for surety bond premiums is the bidder's credit score, with premiums typically ranging from 1 percent to 10 percent of the bid surety bond amount. However, there is no reliable way to estimate the impact of program changes or market conditions because the last round may have impacted bidders' credit profiles. Importantly, the overall

financial burden may be reduced for many suppliers because Round 2021 included 130 competitive bidding areas (CBAs) requiring separate bid surety bonds for each CBA, whereas Round 2028 will include a nationwide RID CBA requiring one bid surety bond. While the cost of one RID bid surety bond would increase because of a $50,000 increase in the bid surety bond amount, suppliers that previously bid in multiple CBAs would likely experience net savings by needing only one bid surety bond instead of multiple bid surety bonds. Suppliers that bid in non-RID CBAs will still require separate $50,000 bonds for each CBA in which they submit a bid. The actual cost impact will vary significantly based on individual credit scores, past performance, and the number of CBAs a supplier would have participated in under a prior round of the DMEPOS CBP. Given these variables, the true impact cannot be precisely quantified and cost estimates should present a range using a 1 percent to 10 percent premium rate framework with caveats about individual variation and the offsetting effect of requiring fewer bid surety bonds.

D. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret the final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume at least one staff in IRFs would read the rule. The total number of IRFs would be the proxy of number of reviewers for this rule. We acknowledge that this assumption may understate or overstate the costs of reviewing the final rule. We also assumed that each reviewer reads 100 percent of the rule.

Using the national median hourly wage data from the May 2025 BLS for Occupational Employment and Wage Statistics (OEWS) for medical and health service managers (SOC 119111), we estimated that the cost of reviewing this rule is $119.10 per hour, including other indirect costs and fringe benefits (*https://www.bls.gov/oes/tables.htm*). Assuming an average reading speed, we estimate that it will take approximately 3 hours for the staff to review the final rule. For each reviewer of the rule, the estimated cost is $357.30 (3 hours × $119.10). Therefore, we estimated that the total cost of reviewing this regulation is $420,899.40 ($357.30 × 1,178 reviewers).

E. Alternatives Considered

1. IRF PPS

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this final rule. As noted previously in this final rule, section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services and section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket percentage increase for FY 2027. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are updating the IRF prospective payments in this final rule by 2.3 percent (which equals the 3.2 percent IRF market basket percentage increase for FY 2027 reduced by a 0.9 percentage point productivity adjustment as determined under section 1886(b)(3)(B)(xi)(II) of the Act (as required by section 1886(j)(3)(C)(ii)(I) of the Act)).

We also considered making no changes to the current IDT meeting policy (42 CFR 412.622(a)(5)) and allow the initial IDT meetings to occur within 7 consecutive calendar days beginning with the date of admission to the IRF (42 CFR 412.622(c)). However, we declined to take this approach given the importance of the IDT meetings for coordinated patient care early in their stay and in shaping revisions to the plan of care if there are problems that could impede the patient's progress toward their rehabilitation goals.

2. IRF QRP

Regarding the proposal to revise the IRF QRP assessment data submission deadline from 4.5 months to no later than the 15th day of the second month after the end of each quarter, we considered keeping the deadline unchanged. We determined that the revised timeframe is a reasonable amount of time for IRFs to submit data and make any necessary corrections, and that the benefits of this shortened timeframe include making the data timelier and more actionable which increases the value of publicly reported data both for consumers and their families and for IRFs to use in their quality improvement activities.

F. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf*), in Table 15, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of the final rule. Table 15 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this final rule based on the data for IRFs in our database.

TABLE 15: Accounting Statement-Classification of Estimated Expenditure

	Category	Transfers
Change in Estimated Transfers from FY 2026 IRF PPS to FY 2027 IRF PPS	Annualized Monetized Transfers	$340 million increase
	From Whom to Whom?	Federal Government to IRF Medicare Providers
Estimated Costs Associated with Review Cost for FY 2027 IRF PPS	Cost associated with regulatory review cost	$420,899

G. Regulatory Flexibility Act (RFA)

1. Anticipated Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $19.0 million to $47.0 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. The SBA defines small specialty hospitals (except Psychiatric and Substance Abuse) as businesses having less than $47.0

million in total annual revenue. We believe NAICS code 622310 (Specialty Hospitals, except Psychiatric and Substance Abuse) is a reasonable proxy for IRFs for purposes of contextualizing industry structure where 40 percent of entities are small business (127 out of 327 entities) according to the Statistics of U.S. Businesses (SUSB) data. For more details, see the Small Business Administration's final rule that set forth size standards for healthcare industries (65 FR 69432) and see the U.S. Small Business Administration Table of Small Business Size Standards, Matched to North American Industry Classification System Codes.[25]

According to the MedPAC 2026 Report to Congress,[26] only 51 percent of IRF stays are Medicare fee-for-service stays. Therefore, we estimate that Medicare constitutes approximately 51 percent of total revenue for all 1,178 IRFs. We invited feedback regarding this assumption.

As shown in Table 16, according to the 2022 Economic Census, all Specialty (except Psychiatric and Substance Abuse) Hospitals, the regulatory review cost is $341 per entity. Table 14 presents the distribution of $340 million increase in total annualized monetized transfers from the Federal Government and States to IRF providers in FY 2027.

The Department of Health and Human Services' (HHS) uses a change in revenue of more than 3 to 5 percent as a measure of economic significant impact. The agency considers the rule to have a significant impact on a substantial number of small businesses when more than 5 percent of impacted small entities meet the significant impact threshold. Although the rule may affect a substantial number of small entities, we do not expect the economic impact on those affected entities to be significant. Table 14 presents the detailed annual transfer payment change from FY 2026 to FY 2027. Taking into account Medicare revenue accounts for around 51 percent of IRFs revenue, the change would be less than 3 percent. As such, we believe even though a substantial number of small businesses might be affected, the impact would not be significant. Finally, the impact implies the increase of payment which is welcomed by small businesses.

TABLE 16: Impact per Entity (NAICS 622310) Specialty (except Psychiatric and Substance Abuse) Hospitals ($47 Million Size Standard)

Firm Size (by Receipts)	Firm Count	% of Small Entities	Average Annual Revenue ($1,000)	Cost per Entity($)	Percentage of Average Revenue
SMALL HOSPITALS ($1,000)	**127**	**100.0%**	**13,613**	**341**	
<100	5	3.9	47	341	0.726
100 - 499	20	15.7	264	341	0.129
500 - 999	6	4.7	832	341	0.041
1,000 -2,499	3	2.4	1,270	341	0.027
2,500 - 4,999	5	3.9	3,987	341	0.009
5,000 - 7,499	4	3.1	6,251	341	0.005
7,500 - 9,999	6	4.7	8,555	341	0.004
10,000 - 14,999	23	18.1	11,115	341	0.003
15,000 - 19,999	18	14.2	16,332	341	0.002
20,000 - 24,999	11	8.7	21,741	341	0.002
25,000 - 29,999	10	7.9	24,600	341	0.001
30,000 - 39,999	8	6.3	28,107	341	0.001
40,000 - 49,999	8	6.3	44,833	341	0.001
LARGE HOSPITALS	198	NA	469,928	341	0.000

Source: 2022 Statistics of U.S. Businesses, available at https://www.census.gov/programs-surveys/susb.html.

H. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4, enacted March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold was approximately $193 million. This final rule does not mandate any requirements for State, local, or Tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. As stated, this final rule will not have a substantial effect on State and local governments, preempt State law, or otherwise have a Federalism implication.

Section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For the purposes of section 1102(b) of the Act, we define a small

[25] *https://www.sba.gov/sites/default/files/2023-06/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%282%29.pdf,* effective January 1, 2022, and updated on March 17, 2023.

[26] *https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf.*

rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 14, we estimate that the net revenue impact of this final rule on rural IRFs is to increase estimated payments by approximately 3.2 percent based on the data of the 127 rural units and 14 rural hospitals in our database of 1,178 IRFs for which data were available. Considering Medicare revenue accounts for 51 percent of the total revenue, we estimate an overall impact for rural IRFs in all areas between 1.2 percent and 2.8 percent of total revenue. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural IRFs.

I. E.O. 14192 ''Unleashing Prosperity Through Deregulation

Executive Order 14192, entitled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations.'' We estimated that this final rule will generate approximately $0.02 million in discounted costs relative to year 2024, over a perpetual time horizon. The Office of Information and Regulatory Affairs has determined that this rule is not an Executive Order 14192 regulatory action because it does not impose more than de minimis regulatory costs.

J. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2027 are projected to increase by 2.7 percent, compared with the estimated payments in FY 2026, as reflected in column 7 of Table 14.

IRF payments per discharge are estimated to increase by 2.7 percent in urban areas and 3.2 percent in rural areas, compared with estimated FY 2026 payments. Payments per discharge to rehabilitation units are estimated to increase 3.4 percent in urban areas and 3.3 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.3 percent in urban areas and 3.1 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this final rule. The largest payment increase is estimated to be 5.5 percent for IRFs in Rural New England. The previously noted analysis, together with the remainder of this preamble, provides an RIA.

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 28, 2026.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Biologics, Diseases, Drugs, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 412.622 is amended—
■ a. By revising paragraphs (a)(3)(ii) and (a)(5)(ii);
■ b. By redesignating paragraph (a)(5)(iii) as paragraph (a)(5)(iv);
■ c. By adding new paragraph (a)(5)(iii); and
■ d. In paragraph (c) by revising the definition of ''Week''.

The revisions and addition read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) * * *

(ii) Except during the emergency period described in section 1135(g)(1)(B) of the Act, patients generally require and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy per week. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. All required therapy treatments and/or therapy evaluations ordered must begin no later than 36 hours from midnight on the day of admission to the IRF.

* * * * *

(5) * * *

(ii) The initial interdisciplinary team meeting must occur on or before 4 days from the date the patient is admitted to implement appropriate treatment services; establish or review the patient's stated rehabilitation goals; and identify any problems that could impede goals.

(iii) The date of the initial interdisciplinary team meeting must be used to determine the patient's subsequent team meetings. The remaining interdisciplinary team meetings must occur at least once per week after the date of the prior team meeting to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.

(c) * * *

Week means a period of 7 consecutive calendar days.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 3. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

■ 4. Section 414.412 is amended by—
■ a. Revising paragraph (g)(2)(i)(H); and
■ b. Adding paragraph (g)(2)(iii).

The revision and addition read as follows:

§ 414.412 Submission of bids under a competitive bidding program.

* * * * *

(g) * * *

(2) * * *

(i) * * *

(H) The bid surety bond amount of $50,000.

* * * * *

(iii) Notwithstanding the above, to submit a bid(s) and be awarded a contract for a RID CBP, the bidding entity must obtain a bid surety bond of $100,000. If submitting bids for multiple competitions under a RID CBP, only one bid surety bond is required, regardless of whether the RID CBP competitions have different CBAs.

* * * * *

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

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