

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2027 and Updates to the IRF Quality Reporting Program [CMS-1845-P]

Summary of Proposed Rule

On April 2, 2026, the Centers for Medicare & Medicaid Services (CMS) made available for public inspection on the *Federal Register* website a proposed rule ([CMS-1845-P](#)) to update the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2027. Additionally, this rule includes updates for the IRF Quality Reporting Program (QRP). CMS also includes two Requests for Information (RFIs) on alternative data sources for IRF PPS wage index and potential future IRF PPS payment reform. CMS makes proposals related to IRF therapy treatments or therapy evaluations, documentation of functional status, and interdisciplinary team meetings. Finally, this rule includes changes to the DMEPOS Competitive Bidding Program. The IRF PPS Addenda, along with other supporting documents and tables referenced in this proposed rule, are available on the CMS website at [CMS-1845-P | CMS](#)

CMS estimates that the Medicare IRF PPS payments in FY 2027 will be about \$355 million higher than in FY 2026. CMS estimates that the proposal related to IRF QRP will not result in any costs or savings to IRFs during FY 2027.

The deadline for comments on this proposed rule is June 1, 2026.

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I. Executive Summary

For the IRF PPS, this proposed rule includes: the 2027 IRF PPS payment rate update; a solicitation of public comments on alternative data sources for the IRF PPS wage index; proposed requirements for all therapy treatments and/or therapy evaluations to begin within 36-hours from midnight on the day of admission; proposed requirements for documentation of a patient’s current functional status in the preadmission screening; proposed requirements for the initial Interdisciplinary Team (IDT) to meet by the 4th day of admission; and a solicitation of comments on options to modernize and revise the primary diagnosis and comorbidity score methodology used under the Skilled Nursing Facility Patient Driven Payment Model (PDMP).

For the IRF QRP, this proposed rule proposes a revision of the data submission deadlines beginning with FY 2029. CMS also seeks comment on future measure concepts.

For the DMEPOS CBP, CMS proposes a higher bid surety bond amount for a bidding entity submitting a bid in Remote Item Delivery (RID) competitive bidding area.

CMS estimates that the Medicare IRF PPS payments in FY 2027 will be about \$355 million higher than in FY 2026. CMS estimates that the proposal related to IRF QRP will not result in any costs or savings to IRFs during FY 2027.

II. Background

In this section of the proposed rule, CMS provides a brief overview of the IRF PPS, which applies to inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital. CMS

reviews the applicable statutory authorities¹ and IRF PPS provisions which are further described in the FY 2002 through 2026 IRF PPS final rules.

CMS also summarizes 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, particularly focusing on the IRF Quality Reporting Program (QRP) that the agency implemented in 2014.

CMS has developed and made public a separate online document to provide detailed background information related to the regulatory and legislative provisions that have affected the IRF PPS over the years. The document also includes details related to claims submission and processing. The document may be found on the CMS website at: [Inpatient Rehabilitation Facility \(IRF\) Prospective Payment System \(PPS\) Regulatory and Legislative History](#)

III. Summary of Provisions of the Proposed Rule

Proposed policy changes and updates to the IRF PPS for FY 2027 include the following:

- Updating the CMG relative weights and average length of stay values for FY 2027 in a budget neutral manner.
- Updating the IRF PPS payment rates for FY 2027 by the IRF market basket percentage increase with a productivity adjustment required under statute.
- Updating the FY 2027 IRF PPS payment rates by the FY 2027 wage index, applying the third 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.
- Soliciting public comments on alternative data sources for the wage index.
- Describing the calculation of the IRF standard payment conversion factor for FY 2027.
- Updating the outlier threshold amount for FY 2027.
- Updating the cost-to-charge (CCR) ceiling and urban/rural average CCRs for FY 2027.
- Requiring all therapy treatments or therapy evaluations to begin within 36 hours from midnight on the day of admission (§412.622(a)(3)(ii)).
- Requiring that the patient's current functional status is documented in the preadmission screening (§412.622(a)(4)(i)(B)).
- Requiring the initial IDT meeting to occur by the 4th day of admission and align with the plan of care (POC) timeframe (§412.622(a)(5)(ii)).
- Soliciting public comments 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 Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to group patients by case mix.

Proposed policy changes and updates to the IRF QRP include revising the IRF QRP data submission deadlines for FY 2029 and soliciting comment on future measure concepts.

¹ Including Section 1886(j) of the Social Security Act establishing the IRF PPS and conferring broad statutory authority on the Secretary to propose refinements to the IRF PPS.

Proposed policy changes and updates to the DMEPOS Competitive Bidding Program (CBP) include requiring a higher bid surety bond amount for a bidding entity submitting under a Remote Item Delivery competitive bidding program.

IV. Proposed Updates to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2027

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (*e.g.*, very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

CMS is proposing updates to the CMG relative weights and average length of stay values for FY 2027 using FY 2025 IRF claims and FY 2024 IRF cost report data using the same methodology as it has in prior years. Changes to the CMG weights are budget neutral. The proposed budget neutrality factor is 0.9990.

Table 2 in the proposed rule displays the relative weights and length of stay values by CMG and comorbidity tier. Table 3 displays the distributional effect of changes in CMS weights across cases. As proposed for FY 2027, 99.4 percent of IRF cases are in CMGs for which the FY 2027 weight differs from the FY 2026 weight by less than 5 percent (either increase or decrease).

CMS indicates that the proposed changes in the average length of stay values from FY 2026 to FY 2027 are small and do not show any trends in IRF length of stay patterns.

Column 6 of Table 15 in the impact section of the proposed rule (reprinted in section XII of this summary) shows the distributional effects of the changes in the CMGs by type of facility.

V. FY 2027 IRF PPS Payment Update

A. Background

CMS is required by sections 1886(j)(3)(C)(i) and 1886(j)(3)(C)(ii)(I) of the Act to establish the IRF PPS update based on a market basket percentage increase less a productivity adjustment.

B. Proposed FY 2027 Market Basket Update and Productivity Adjustment

CMS is proposing an update factor of 2.4 percent to the IRF PPS payment rates for FY 2027 as shown below.

Proposed FY 2027 IRF PPS Update Factor	
IRF market basket	3.2%
Total factor productivity (TFP)	-0.8
Total	2.4%

The proposed update reflects IHS Global Insight’s (IGI’s) 4th quarter 2025 forecast of the IRF market basket with historical data through the 3rd quarter of 2025. The productivity offset is based on IGI’s 4th quarter 2025 forecast of the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity.² The update factor will be 2.0 percentage points lower for IRFs that fail to meet IRF QRP requirements. The update and productivity figures will be updated in the final rule based on more recent data.

In its March 2026 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress should reduce the IRF PPS base payment rate by 7 percent for FY 2027.³ By law, CMS must update IRFs rates by the market basket less productivity and cannot adopt MedPAC’s recommendation.

C. Proposed FY 2027 Labor-Related Share

CMS is proposing a total labor-related share of 74.5 percent (the sum of 70.8 percent for operating costs’ labor share, and 3.7 percent for capital costs’ labor share) for FY 2027, which is 0.1 percentage point higher than the FY 2026 labor share of 74.4 percent as shown in Table 4 below reproduced from the proposed rule:

Table 4: Proposed IRF Labor Related Share

	FY 2026	FY 2027*
Wages and Salaries	49.4	49.5
Employee Benefits	11.8	11.8
Professional Fees: Labor-related	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	70.7	70.8
Labor-related portion of capital (46%)	3.7	3.7
Total Labor Related Share	74.4	74.5

* Based on the 4th quarter 2025 IHS Global Inc. forecast of the 2021-based IRF market basket.

² [Productivity Home Page : U.S. Bureau of Labor Statistics](#)

³ [MedPAC – MedPAC](#)

D. Proposed Wage Adjustment for FY 2027

1. Proposed FY 2027 Wage Index

CMS is proposing to continue to use the Office of Management and Budget's (OMB) core-based statistical areas (CBSAs) as the labor market areas for the IRF PPS and the FY 2027 pre-reclassification and pre-floor hospital IPPS wage indexes. In cases where there is a rural area without IPPS wage data but an IRF wage index needs to be assigned, CMS will continue to use the average wage index from all contiguous CBSAs. For urban areas where there are no IPPS hospitals but an IRF wage index needs to be assigned, CMS will use the urban area average for the state in which the IRF is located.⁴ CMS proposes to continue applying 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.⁵

In the proposed rule, CMS indicates that it began using Bureau of Labor Statistics (BLS) occupation-level wage data for the wage index in calendar year 2025 for the End Stage Renal Disease Prospective Payment System (89 FR 89116). In its 2023 Report to Congress, MedPAC explored using county-level wage data from BLS to construct wage indexes specific to the payment setting. **CMS is soliciting comments on using alternative data sources such as BLS to construct an IRF-specific wage index for potential use in future years.** The proposed rule further indicates that CMS is considering the potential use of alternative data for the wage index in the prospective payment systems for inpatient psychiatric facilities, skilled nursing facilities and hospices.

2. Phase Out of the Rural Adjustment

As a result of some counties transitioning from a rural designation to an urban one under the 2023 OMB definitions adopted in FY 2025, eight IRFs would lose their rural status for purposes of the 14.9 percent rural payment adjustment. In the FY 2025 IRF PPS final rule, CMS adopted a policy to phase-out the rural adjustment for these IRFs over three-years (FY 2025, FY 2026, and FY 2027). For FY 2027, the phase out of the rural adjustment for these hospitals will be complete. These hospitals will not receive any rural adjustment.

3. IRF Budget-Neutral Wage Adjustment Factor

To determine the proposed FY 2027 IRB PPS wage index budget neutrality factor, CMS estimates aggregate IRF PPS payments using the FY 2026 labor-related share and wage index and then estimates aggregate payments using the proposed FY 2027 labor share and wage index. The ratio of the FY 2026 payments and the proposed FY 2027 payments is the proposed budget

⁴ For FY 2027, the only rural area without wage index data available is in North Dakota, and the only urban area without wage index data available is CBSA 25980, Hinesville Fort Stewart, GA.

⁵ New IRFs would be paid the wage index for the area in which they are geographically located for their first full or partial FY with no cap applied.

neutrality adjustment to be applied to the proposed federal per diem base rate for FY 2027. CMS is proposing a budget neutrality adjustment of 1.0033.

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

Table 5 of the proposed rule (reproduced below) shows the calculations used to determine the proposed FY 2027 IRF standard payment amount. In addition, [Table 6](#) of the rule lists the FY 2027 proposed payment rates for each case-mix group (CMG).

Table 5: Calculations to Determine the FY 2027 IRF Standard Payment Conversion Factor	
Explanation for Adjustment	Calculations
Standard Payment Conversion Factor for FY 2026	\$19,371
Market Basket Less Productivity	x 1.024
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0033
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9990
Proposed FY 2027 Standard Payment Conversion Factor	= \$19,881

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

[Table 7](#) provides a detailed hypothetical example of how the IRF FY 2027 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRFs (one urban, teaching with a disproportionate share (DSH) percentage of 15 percent and one rural, non-teaching with a DSH percentage of 5 percent) using the applicable proposed rule wage index values and facility-level adjustment factors.

VI. Proposed Update to Payments for High-Cost Outliers under the IRF PPS for FY 2027

A. Proposed Update to the Outlier Threshold Amount for FY 2027

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF’s overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF PPS, CMS’ intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments. CMS proposes to continue this policy for FY 2027. CMS believes this level reduces financial risk to IRFs of caring for high-cost patients while still providing adequate payments for all other cases.

To update the IRF outlier threshold amount for FY 2027, CMS proposes to use FY 2025 claims data and the same methodology that has been used to set and update the outlier threshold since FY 2002 (66 FR 41362-41363). CMS estimates that IRF outlier payments are 2.6 percent of total IRF payments for FY 2026. To maintain estimated IRF outlier payments at the 3 percent of total IRF payments, CMS proposes to update the outlier threshold amount from \$10,141 for FY 2026

to \$8,689 for FY 2027. CMS will update the outlier threshold in the final rule using more recent data.

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

CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining outlier payment amounts. The national urban and rural CCRs are applied in the following situations:

new IRFs that have not yet submitted their first Medicare cost report;
IRFs with an overall CCR that is more than the national CCR ceiling for FY 2025; and
other IRFs for which accurate data to calculate an overall CCR are not available.

The national CCR ceiling for FY 2027 would continue to be set at three standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the national average CCR (either urban or rural).

CMS proposes national average cost weighted CCRs for FY 2027 of 0.386 for urban IRFs and 0.461 for rural IRFs. The proposed national CCR ceiling is 1.54. If an individual IRF's CCR exceeds 1.54 for FY 2027, CMS will replace the IRF's CCR with the applicable urban or rural national average CCR.

VII. Proposals to Revise the Basis of Payment Requirements

A. Proposal on the Initiation of Therapies Within 36 Hours from Admission

Currently, in order 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 per day at least 5 days per week. The "required therapy treatments and/or therapy evaluations for IRF patients must begin within 36 hours from midnight of the day of admission to the IRF" (42 CFR 412.622(a)(3)(ii)). CMS believes that subregulatory guidance the agency posted in 2010 may have created ambiguous policy interpretation as to whether only one therapy or all therapies must be initiated within 36 hours from the day of admission to the IRF. CMS states that therapy evaluations are generally considered to constitute the beginning of the required therapy services and may count towards meeting the 36-hour requirement, however, all therapies must be initiated, not just one therapy to meet the policy regulation.

CMS therefore proposes to revise 42 CFR 412.622(a)(3)(ii) to state that "[a]ll required therapy treatments and/or therapy evaluations must begin no later than 36 hours from midnight the day of admission to the IRF." In the absence of compliance with this new requirement, if finalized, an IRF claim would not be considered reasonable and necessary (in accordance with section 1862(a)(1) of the Act).

B. Proposal to Update the Documentation of Current Functional Status in the Preadmission Screening

Currently, under 42 CFR 412.622(a)(4)(i), in order for an IRF claim to be considered reasonable and necessary, IRFs are required to document a comprehensive preadmission screening to indicate that a patient meets the requirements for an IRF admission. The preadmission screening must include, among other things, “the patient’s level of function prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy.”

CMS believes that in order for the IRF to develop an appropriate plan of care for the patient, in addition to documentation of the patient’s prior level of function, the IRF should also document the patient’s current functional status in the preadmission screening. **CMS therefore proposes to revise §412.622(a)(4)(i)(B) to additionally require that the patient’s “current functional status” be documented in the patient’s preadmission screening in their medical record at admission.**

C. Proposed Initial Interdisciplinary Team (IDT) Meeting

Currently, in order for an IRF claim to be considered reasonable and necessary, the IRF must fulfill several requirements specified at §412.622(a)(4) and (5). These include the development of a plan of care (POC) by a rehabilitation physician with input from an interdisciplinary team (IDT) within 4 days of the patient’s admission to the IRF. Additionally, the IRF must document weekly interdisciplinary team meetings during which all members of a patient’s IRF care team must review the patient’s progress toward their rehabilitation goals, making recommendations for therapy changes to support discharge goals. CMS notes that prior guidance provided to IRFs says the initial IDT meeting may occur on day 8 from the day of admission, which is not aligned with the current policy.

CMS expresses concern that under the current IDT policy, 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. 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. CMS believes that the IDT 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.

Therefore, **CMS proposes to revise §412.622(a)(5)(ii) to specify that the first IDT meeting shall occur on or before the fourth day from midnight on 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.** The initial IDT would be in coordination with the development and timing of the patient’s start of therapy (per

the 36-hour rule) and the POC. Following the initial IDT meeting, **CMS further proposes that a patient’s subsequent IDT meetings occur weekly** (for example, within 7 days from the prior IDT meeting). In addition to these revisions, **CMS proposes 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. **CMS also proposes 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.

In the preamble, CMS provides Figure 1 and Table 8 which provide examples of when IDT meetings occur based on the date the prior IDT was conducted. The Figure and Table are reproduced here:

FIGURE 1: Proposed Initial Interdisciplinary Team Meeting Policy

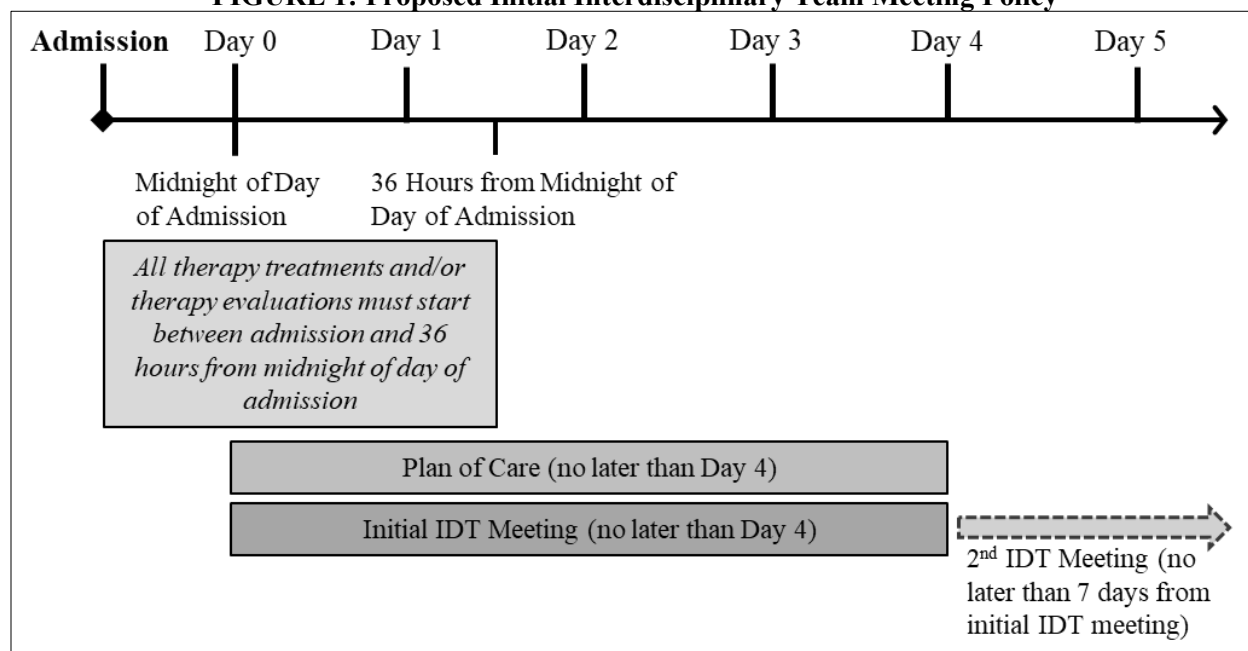


TABLE 8: Compliant and Non-Compliant IRF Patient Examples of IDT Timeline

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 noncompliant as there were more than 4 days between admission and the initial IDT.

In the preamble, CMS provides a description of the simulation exercise it conducted to assess the impact of the proposed initial IDT policy on IRFs. Assuming the IDT meetings would be 1 hour in duration, IRFs that move from once to the twice weekly IDT meeting frequency would face an additional approximate cost of \$399.06 per week.

VIII. Request for Information Regarding Future IRF Payment Reform

CMS is exploring opportunities to modernize the IRF PPS 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 groupings. In this section of the proposed rule, CMS provides an overview of the current IRF PPS patient classification system and requests input on future payment reforms to enhance and modernize the IRF payment structure.⁶

A. Background and the Need for Payment Reform

Under the IRF PPS, providers report an Impairment Group Code (IGC) in Item 21A of the IRF Patient Assessment Instrument (IRF-PAI)⁷ to identify the primary reason the patient requires IRF care. Each IGC maps to a single Rehabilitation Impairment [Category] (RIC),⁸ which serves as the first level of classification in the payment system. The CMS grouper uses the RIC to assign the patient to a case mix group (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 FIMTM instrument.⁹ In the FY 2019 final rule (83 FR 38514), CMS removed the FIMTM instrument and associated Function Modifiers and adopted IRF-PAI Quality Indicator items to

⁶ Additional background information for the IRF PPS 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.

⁷ The IRF-PAI is the assessment instrument IRF providers use to collect patient assessment data for quality measure calculation and payment determination in accordance with the IRF QRP.

⁸ In the preamble, CMS uses the term “code”, however, HPA believes this was a typo and that the term should be “category”.

⁹ The Functional Independence Measure (FIM) is a standardized assessment tool designed to evaluate an individual’s level of disability and track changes in functional status over time. It specifically measures the degree of assistance required for performing activities of daily living, encompassing areas such as self-care, mobility, communication, and social cognition.

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.

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, and that the IRF PPS is updated to reflect changes in patient complexity and advances in rehabilitation care since its implementation in 2002. 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. CMS notes that these potential refinements would be similar to those used in other Medicare payment systems, including the Inpatient Psychiatric Facility (IPF) PPS and the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM). CMS also cites MedPAC analyses that support this need for refinement.¹⁰

In this comment solicitation, CMS seeks 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. In its discussion for both of the specific potential changes, CMS indicates that its analyses are available in “a technical report” found at: [Research | CMS](#).¹¹

B. Potential Changes to IRF Patient Clinical Classification

The IRF PPS currently relies on 17 major category IGCs, comprising 85 specific IGCs, 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 multistep 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.

¹⁰ See: MedPAC Reports to the Congress on Medicare Payment Policy, March 2023, March 2025, and March 2026.

¹¹ HPA notes that there are several reports on the website indicated by CMS, all of which appear to be fairly old. Additionally, CMS does not specify to which report it is referring.

To address these limitations, CMS is considering 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 15 IRF-specific clinical categories to reflect the primary reason for the IRF stay (see Table 9, reproduced from the preamble of the proposed rule). These proposed categories would modernize IRF patient classification by replacing the current mapping scheme with a comprehensive and exhaustive crosswalk from ICD-10-CM diagnosis codes directly to IRF PPS clinical categories.

CMS notes that these proposed 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. **CMS is soliciting public comments on the potential use of these clinical category assignments under the IRF PPS to classify a patient for payment purposes.**

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

C. 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. 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 (reproduced from the preamble), 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. CMS believes that 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. **CMS is soliciting public comments on the potential use of comorbidity scores and score bins under the IRF PPS to categorize comorbidities for payment purposes.**

TABLE 10: Potential Comorbidity Score Bins

Potential Bins	Potential Comorbidity Score in Each Bin
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+

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

A. Background and Statutory Authority

The IRF QRP is authorized under section 1886(j)(7) of the Act. The program is applicable to freestanding IRFs and to inpatient rehabilitation units of hospitals or critical access hospitals (CAHs). By statute, a facility that does not submit data in accordance with the IRF QRP requirements for a rate year is subject to a 2.0 percentage point reduction in the update factor for that year. FY 2014 was the first IRF PPS rate year in which the IRF QRP affected payments.¹²

The IRF standardized patient assessment instrument (IRF-PAI) is used for data collection and reporting and includes standardized patient assessment data elements (SPADEs) that are interoperable and common across post-acute care (PAC) providers. Measures remain in the IRF

¹² A detailed legislative and regulatory history is available for download from the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS>. Additional information about the program is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting>.

QRP until they are removed, suspended, or replaced. Section 1899B(b)(1)(B)(vi) of the Act authorizes the Secretary to collect other categories of data through the IRF-PAI.

CMS is proposing to revise the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. CMS also seeks public comment on an RFI on future measure concepts.

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

CMS refers readers to 42 CFR §412.634(b)(2) for details on factors used to evaluate whether a measure should be removed from the IRF QRP, and to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084) for considerations CMS uses for selecting quality, resource use, and other measures. The table below (Table 11 reproduced from the proposed rule with minor modifications) shows the current measures for the IRF QRP.

Table 11. Quality Measures Currently Adopted for the IRF QRP

Short Name	Measure Name & Data Source
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–PAC IRF QRP
TOH-Provider	Transfer of Health Information to the Provider–PAC Measure
TOH-Patient	Transfer of Health Information to the Patient–PAC Measure
DC Function	Discharge Function Score Measure
National Healthcare Safety Network (NHSN)	
CAUTI	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
CDI	NHSN Facility-wide Inpatient Hospital-Onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
Claims-based	
MSPB IRF	Medicare Spending per Beneficiary (MSPB)–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 - Request for Information (RFI)

In the FY 2024 IRF PPS proposed rule (88 FR 21000 through 21003), CMS requested information on a set of principles for selecting and prioritizing IRF QRP measures, identifying measurement gaps and suitable measures for filling these gaps. In this proposed rule, CMS now seeks input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advance care planning, and specifically relevant aspects of advance care planning and measures appropriate for the IRF setting. The agency states it will prioritize evidence-based outcome measures that promote person-centered care practices.

D. Form, Manner, and Timing of Data Submission Under the IRF QRP: Proposal to Revise IRF QRP Data Submission Deadlines Beginning With FY 2029 IRF QRP

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. Currently, for IRF-PAI assessment-based measures, IRFs have approximately 4.5 months (135 days) after each quarterly data collection period to complete their data submissions to CMS for purposes of compiling public performance reports and make corrections to such data where necessary. There are also three IRF QRP measures submitted through the CDC NHSN. For the NHSN CAUTI and CDI outcome measures, IRFs must submit data no later than 4.5 months after the end of the reporting quarter. For the Influenza Vaccination Coverage among HCP measure, the data collection period is October 1 through March 31 with a data submission deadline of May 15th.

In evaluating this process, CMS has determined that the total time between when data on measures is collected and submitted to CMS and when that data are publicly reported (that is, approximately 9 months) may be too long to provide the most accurate and up to date information for the public. CMS believes that reducing the IRF QRP data submission deadline from 4.5 months after the calendar quarter to instead be the 15th day of the second month after the end of the calendar quarter would improve the timeliness of public reporting by one quarter, which could be beneficial to both consumers and IRFs, with limited change in burden to IRFs. To this end, in the FY 2026 IRF PPS proposed rule, CMS issued an RFI on reducing the assessment data submission deadline from 4.5 months to 45 days.

CMS is now proposing that, beginning with the FY 2029 IRF QRP, IRFs would be required to complete data submissions and make corrections, as necessary, to their IRF-PAI assessment data and CDC NHSN data not later than the 15th day of the second month after the end of the calendar quarter, except if such 15th day falls on a Friday, weekend, or Federal holiday the deadline would be delayed until the next business day. The proposed data submission deadline is approximately within 45 days of the end of the quarter. According to an analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using 2024 data, 99.08 percent of all IRF-PAI assessments were submitted within a 45-day period. According to another analysis

conducted by CMS on the potential impact of shortening the data submission timeframe, using FY 2025 data, 88.5 percent of all IRFs submitted CDC NHSN data within a 45-day period.

The specific data submission deadlines proposed for the FY 2029 IRF QRP for IRF-PAI assessment data are shown in Table 12 of the rule and for CDC NHSN QRP measures are shown in Table 13 of the rule. Both tables are shown below. The agency proposes that similar calendar year data submission deadlines would apply for future years.

Table 12: Proposed Data Collection Timeframe and Data Submission Deadlines for IRF-PAI Assessment Data Affecting 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

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

Measure	Data Collection Timeframe	Final Data Submission Deadlines for FY 2029 Payment Determination
CAUTI and 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

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

CMS is not proposing any policies on the public display of measure data.

X. Proposed Change to the DMEPOS Competitive Bidding Program (CBP)

A. Background

Under CMS’ DMEPOS CBP, 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) 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.¹³ 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

¹³ See: 2016 ESRD PPS and DMEPOS final rule (81 FR 77834), and as codified at 42 CFR 414.412(g).

entity does not accept the contract offered, the bid surety bond(s) for the applicable CBA(s) will be forfeited and the Secretary will collect on the bid surety bond(s). 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, 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 product category and area.

CMS explains that 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.

In the 2026 HH PPS final rule (90 FR 55342-55620), CMS established the Remote Item Delivery (RID) CBP 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. Items falling under a RID CBP are those 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. When implementing the RID CBP, CMS stated its intent to implement RID CBPs for certain items designated under the DMEPOS CBP, and further explained that competitions for RID items may involve larger CBAs, including nationwide CBAs.

B. Provisions of the Proposed Regulation

To discourage DMEPOS suppliers from submitting non-serious or disingenuous bids and to ensure genuine commitment from suppliers awarded contracts under a RID CBP, **CMS is proposing to require 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. CMS provides several justifications for this amount, including its belief that the significantly greater scale, complexity, and beneficiary population associated with a RID CBA warrants the highest available level of financial commitment from bidders. **CMS proposes to maintain the bid surety bond amount of \$50,000 for all non-RID competitions.**

Additionally, **CMS proposes 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 CBA bids.** Rather than implementing hundreds of separate local CBPs and CBAs—which would impose unnecessary administrative burden on both the bidding program and suppliers—CMS believes 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 2026 HH PPS Final Rule (90 FR 29254).

CMS notes that this approach is consistent with a September 2004 GAO report (GAO-04-765), which recommended that CMS explore mail delivery as a viable competitive bidding strategy for items provided directly to beneficiaries in the home.

CMS proposes to revise §414.412(g)(2) to implement these proposed changes. Additionally, **CMS proposes to no longer use the term “bid bond value” and instead use the more common term “bid surety bond amount.”**

VIII. Collection of Information Requirements

In compliance with the Paperwork Reduction Act of 1995, CMS is required to solicit comments on the need for the information collection and its usefulness in carrying out the proper functions of the agency, the accuracy of CMS’ estimates of the information collection burden, the quality, utility, and clarity of the information to be collected, and recommendations to minimize the information collection burden on the affected public, including automated collection techniques. CMS is therefore seeking comment on each of these issues for the proposed updates related to the IRF QRP. CMS indicates its belief that the proposal to revise the IRF QRP submission deadlines would not result in additional collection burden or revisions to the currently approved IRF-PAL (OMB control number 0938-0842, expiration 10/31/2027).

IX. Regulatory Impact Analysis

CMS estimates that the proposed rule will increase Medicare payments to IRFs by \$355 million, or 2.8 percent, in FY 2027 compared with FY 2026. This reflects the 3.2 percent increase from the update factor, a -0.8 percent productivity adjustment, and a 0.4 percent increase in estimated IRF outlier payments. Table 15 in the proposed rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes involving the wage index and labor-related shares and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on aggregate payments to IRFs.

TABLE 15: Proposed 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)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,175	473,977	0.4	0.0	0.0	2.8
Urban unit	644	148,744	0.9	0.1	0.0	3.5
Rural unit	127	16,718	0.7	0.3	-0.1	3.4

Urban hospital	390	300,159	0.2	-0.1	0.0	2.5
Rural hospital	14	8,356	0.1	0.8	-0.1	3.2
Urban For-Profit	500	300,413	0.2	-0.1	0.0	2.5
Rural For-Profit	39	12,180	0.3	0.6	-0.1	3.2
Urban Non-Profit	457	130,124	0.8	0.0	0.0	3.3
Rural Non-Profit	84	10,997	0.8	0.3	-0.1	3.3
Urban Government	77	18,366	1.0	0.5	0.0	4.0
Rural Government	18	1,897	0.7	0.5	0.0	3.6
Urban	1,034	448,903	0.4	0.0	0.0	2.8
Rural	141	25,074	0.5	0.4	-0.1	3.3
Urban by region						
Urban New England	31	17,230	0.2	0.2	0.0	2.8
Urban Middle Atlantic	111	43,573	0.6	0.4	0.0	3.4
Urban South Atlantic	197	109,833	0.4	0.1	0.0	2.9
Urban East North Central	165	52,811	0.5	-0.2	0.0	2.6
Urban East South Central	55	30,643	0.1	-0.8	0.0	1.7
Urban West North Central	79	26,901	0.5	0.6	0.0	3.4
Urban West South Central	213	99,115	0.2	-0.4	0.0	2.3
Urban Mountain	84	39,600	0.3	-0.1	0.0	2.6
Urban Pacific	99	29,197	1.2	0.3	0.1	4.0
Rural by region						
Rural New England	5	1,040	0.6	2.5	0.0	5.6
Rural Middle Atlantic	11	1,431	0.5	0.4	-0.2	3.2
Rural South Atlantic	16	6,711	0.1	1.1	-0.2	3.5
Rural East North Central	22	2,997	0.9	0.6	-0.1	3.9
Rural East South Central	18	3,138	0.4	0.4	0.0	3.2
Rural West North Central	18	2,341	1.0	0.3	0.0	3.6
Rural West South Central	44	7,050	0.6	-0.5	-0.1	2.4
Rural Mountain	5	253	0.9	-1.0	0.0	2.3
Rural Pacific	2	113	1.8	-0.6	-0.3	3.2

Teaching status						
Non-teaching	1,067	420,684	0.4	-0.1	0.0	2.7
Resident to ADC less than 10%	64	38,687	0.5	0.5	0.0	3.5
Resident to ADC 10%-19%	33	12,157	1.1	0.8	0.1	4.4
Resident to ADC greater than 19%	11	2,449	0.6	0.3	0.0	3.3
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	48	12,552	0.6	-0.1	0.0	3.0
DSH PP <5%	237	129,880	0.2	-0.1	0.0	2.5
DSH PP 5%-10%	268	113,333	0.3	0.0	0.0	2.7
DSH PP 10%-20%	380	150,661	0.5	0.2	0.0	3.1
DSH PP greater than 20%	242	67,551	0.7	-0.2	0.1	3.1

*This column includes the impact of the updates in columns (4), (5), and (6) above, and of the proposed IRF market basket update for FY 2027 of 3.2 percent, reduced by 0.8 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.