aquifer.'' *Science of the Total Environment,* Volumes 468–469, Pages 384–393, 15 January 2014.
USEPA. 2018. Basic Information on PFAS. Available at: *https://www.epa.gov/pfas/basic-information-pfas.*
USEPA. 2019. EPA's Per- and Polyfluoroalkyl Substances (PFAS) Action Plan. EPA 823–R–18–004, February 2019. Available at: *https://www.epa.gov/sites/production/files/2019-02/documents/pfas_action_plan_021319_508compliant_1.pdf.*
USEPA. 2022a. Drinking Water Contaminant Candidate List 5-Final. **Federal Register**. Vol. 87, No. 218. P. 68060, November 14, 2022.
USEPA. 2022b. Review of the EPA's Draft Fifth Contaminant Candidate List (CCL 5). EPA–SAB–22–007, August 19, 2022.
USEPA. 2023a. Drinking Water Contaminant Candidate List 6-Nominations. **Federal Register**. Vol. 88, No. 33. P. 10316, February 17, 2023.
USEPA. 2023b. Endocrine Disruptor Screening Program (EDSP) Estrogen Receptor Bioactivity. *https://www.epa.gov/endocrine-disruption/endocrine-disruptor-screening-program-edsp-estrogen-receptor-bioactivity.* Accessed June 2023.
USEPA. 2025. Announcement of Preliminary Regulatory Determinations for Contaminants on the Fifth Drinking Water Contaminant Candidate List. **Federal Register** Vol 90 Number 9 Page 3830. January 15, 2025.
USEPA. 2026a. Technical Support Document for the Draft Sixth Contaminant Candidate List (CCL 6)—Chemical Contaminants. EPA 815–R–26–004, February 2026.
USEPA. 2026b. Technical Support Document for the Draft Sixth Contaminant Candidate List (CCL 6)—Contaminant Information Sheets. EPA 815–R–26–005, February 2026.
USEPA. 2026c. Technical Support Document for the Draft Sixth Contaminant Candidate List (CCL 6)—Microbial Contaminants. EPA 815–R–26–006, February 2026.
Zarus, G.M., Muianga, C., Hunter, C.M., and Pappas, R.S. ''A Review of Data for Quantifying Human Exposures to Micro and Nanoplastics and Potential Health Risks.'' *Science of the Total Environment,* Volume 756, 20 February 2021.

Jessica L. Kramer,

Assistant Administrator.

[FR Doc. 2026–06662 Filed 4–3–26; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 414

[CMS–1845–P]

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: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2027. As required by statute, this proposed rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2027. It also continues the third year of the 3-year phaseout of the rural adjustment, which began in FY 2025. This proposed rule includes a solicitation for public comments on alternative data sources for the IRF PPS wage index; proposes to require all therapy treatments or therapy evaluations to begin within 36-hours from midnight on the day of admission; proposes to require a patient's current functional status be documented on the preadmission screening; proposes requirements for the initial Interdisciplinary Team meeting; and includes a request for information on potential future IRF PPS payment reform. Additionally, the proposed rule includes updates to the IRF Quality Reporting Program. Furthermore, the proposed rule includes changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by June 1, 2026.

ADDRESSES: In commenting, please refer to file code CMS–1845–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov/docket/CMS-2026-1024.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1845–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1845–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

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, *Patricia.Taft@cms.hhs.gov,* for readers who experience problems accessing online IRF–PPS documents.

Ariel Cress, (410) 786–8571, for information about the IRF quality reporting program.

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule

may be found at *https://www.regulations.gov.*

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 proposed rule, are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.* The technical reports that describe the analyses CMS conducted referenced in the payment reform RFI (Section VIII. of this proposed rule) 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-and-legislative-history.pdf.*

I. Executive Summary

A. Purpose

This proposed rule would update 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 proposed rule includes the classification and weighting factors for the IRF prospective payment system (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, the proposed rule includes a solicitation for public comments on alternative data sources for the IRF PPS wage index; proposes requirements by revising § 412.622(a)(3)(ii) to require all therapy treatments and/or therapy evaluations to begin within 36-hours from midnight on the day of admission (hereafter referred to as the 36-hour rule); proposes to revise § 412.622(a)(4)(i)(B) to require documentation of a patient's current functional status in the preadmission screening; proposes requirements for the initial Interdisciplinary Team (IDT) by revising § 412.622(a)(5) to require the meeting to occur by the 4th day of admission to align with the Plan of Care (POC) timeframe; and includes 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 proposed rule proposes the revision of the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. We are also soliciting public comments through one 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 proposes a higher bid surety bond amount for a bidding entity submitting a bid in Remote Item Delivery (RID) competitive bidding area.

B. Summary of Major Provisions

In this proposed 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 proposed rule. In addition, the proposed rule includes a proposal to revise the 36-Hour Rule at § 412.622(a)(3)(ii) to require all therapy treatments or therapy evaluations to begin within 36-hours from midnight on the day of admission, proposal to revise § 412.622(a)(4)(i)(B) to require documentation of a patient's current functional status in the preadmission screening and a proposal for an initial IDT meeting policy (§ 412.622(a)(5)(ii)) to occur by the 4th day of admission to align with the POC timeframe.

The IRF proposed rule also provides 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 (PDPM). Additionally, we are soliciting comments 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.

For the IRF QRP, this proposed rule would propose a revision to the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP. We are also soliciting public comments through one RFI on future measure concepts for the IRF QRP.

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 proposed rule is an estimated $355 million increase in payments from the Federal Government to IRFs during FY 2027.
FY 2027 IRF QRP changes	The proposals related to the IRF QRP will not result in any costs or savings to IRFs 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/files/document/irf-regulatory-and-legislative-history.pdf.*

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 proposed 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-and-legislative-history.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 proposed rule, we refer to the two statutes collectively as the ''Affordable Care Act'' or ''ACA''.

The ACA 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 ACA 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 proposed 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 ACA 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 ACA 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/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* 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/quality-safety-oversight-general-information/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/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/ElectronicBillingEDITrans/* 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 Proposed Rule

In this FY 2027 IRF PPS proposed rule, we are proposing to update the IRF PPS for FY 2027 and the IRF QRP for FY 2027 and FY 2029.

The proposed 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 proposed 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 proposed rule.
- Update 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, as discussed in section V. of this proposed rule.
- Solicit public comments on alternative data sources for the wage index, as discussed in section V. of this proposed rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2027, as discussed in section V. of this proposed rule.
- Update the outlier threshold amount for FY 2027, as discussed in section VI. of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2027, as discussed in section VI. of this proposed rule.
- Proposal to require all therapy treatments or therapy evaluations to begin within 36-hours from midnight on the day of admission (§ 412.622(a)(3)(ii)), as discussed in section VII. of this proposed rule.
- 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 proposed rule.
- Proposal to require the initial IDT meeting to occur by the 4th day of

admission and align with the POC timeframe (§ 412.622(a)(5)(ii)), as discussed in section VII. of this proposed rule.

- 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 Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to group patients by case mix, as discussed in section VIII. of this proposed rule.

The proposed policy changes and updates to the IRF QRP for FY 2029 are as follows:

- Revise the IRF QRP data submission deadlines.
- Request for information on future measure concepts.
- The proposed 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. Proposed Updates to the CMG Relative Weights and Average Length of Stay (ALOS) Values for FY 2027

As specified in § 412.620(b)(1), 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 proposed rule, we would update the CMG relative weights and 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 are using 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 proposed 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 this FY 2027 IRF PPS proposed rule, we are proposing 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 CMG relative weights and ALOS values in the final rule.

We propose 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 proposed 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 proposing to update 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 this 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 proposed rule, we discuss the proposed use of the existing methodology to calculate the proposed standard payment conversion factor for FY 2027.

In Table 2, ''Proposed Relative Weights and Average Length of Stay Values for Case -Mix Groups,'' we present the proposed 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.

BILLING CODE 4120–01–P

TABLE 2: Proposed 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	0.9844	0.8447	0.7705	0.7391	9	9	9	8
0102	Stroke M >=63.50 and M <72.50	1.2538	1.0759	0.9814	0.9414	11	11	10	10
0103	Stroke M >=50.50 and M <63.50	1.6081	1.3799	1.2587	1.2074	13	14	13	13
0104	Stroke M >=41.50 and M <50.50	2.0341	1.7455	1.5921	1.5272	17	17	16	16
0105	Stroke M <41.50 and A >=84.50	2.5913	2.2236	2.0282	1.9456	21	22	19	19
0106	Stroke M <41.50 and A <84.50	2.9542	2.5351	2.3123	2.2180	24	24	22	22
0201	Traumatic brain injury M >=73.50	1.1120	0.8824	0.8093	0.7588	10	9	9	8
0202	Traumatic brain injury M >=61.50 and M <73.50	1.3719	1.0887	0.9984	0.9362	11	12	10	10
0203	Traumatic brain injury M >=49.50 and M <61.50	1.7228	1.3671	1.2537	1.1756	14	14	13	12
0204	Traumatic brain injury M >=35.50 and M <49.50	2.1321	1.6919	1.5516	1.4549	17	17	15	15
0205	Traumatic brain injury M <35.50	2.7604	2.1905	2.0089	1.8837	27	22	19	18
0301	Non-traumatic brain injury M >=65.50	1.2279	0.9412	0.8834	0.8173	10	9	9	9
0302	Non-traumatic brain injury M >=52.50 and M <65.50	1.5816	1.2123	1.1378	1.0528	13	12	11	11
0303	Non-traumatic brain injury M >=42.50 and M <52.50	1.9185	1.4706	1.3802	1.2770	15	14	13	13
0304	Non-traumatic brain injury M <42.50 and A >=78.50	2.2528	1.7268	1.6207	1.4995	18	16	15	15
0305	Non-traumatic brain injury M <42.50 and A <78.50	2.4421	1.8719	1.7569	1.6255	20	18	17	16
0401	Traumatic spinal cord injury M >=56.50	1.3111	1.1276	1.0549	0.9621	13	12	11	11
0402	Traumatic spinal cord injury M >=47.50 and M <56.50	1.6356	1.4067	1.3160	1.2002	14	14	14	13
0403	Traumatic spinal cord injury M >=41.50 and M <47.50	2.0796	1.7885	1.6732	1.5260	18	17	17	16
0404	Traumatic spinal cord injury M <31.50 and A <61.50	3.1015	2.6673	2.4955	2.2759	23	32	25	18
0405	Traumatic spinal cord injury M >=31.50 and M <41.50	2.5838	2.2221	2.0790	1.8960	23	21	20	20
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50	3.2045	2.7559	2.5784	2.3515	25	28	24	24
0407	Traumatic spinal cord injury M <24.50 and A >=61.50	4.4781	3.8512	3.6031	3.2860	53	37	32	32
0501	Non-traumatic spinal cord injury M >=60.50	1.2720	1.0068	0.9452	0.8793	12	10	10	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50	1.5597	1.2345	1.1589	1.0781	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	1.7609	1.3937	1.3084	1.2172	14	14	13	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50	2.1134	1.6727	1.5703	1.4608	19	16	15	15
0505	Non-traumatic spinal cord injury M <39.50	2.9583	2.3415	2.1981	2.0449	25	22	21	20
0601	Neurological M >=64.50	1.3672	1.0013	0.9323	0.8546	10	10	9	9
0602	Neurological M >=52.50 and M <64.50	1.7013	1.2460	1.1601	1.0634	13	12	11	11
0603	Neurological M >=43.50 and M <52.50	1.9961	1.4619	1.3612	1.2477	15	14	13	13
0604	Neurological M <43.50	2.5172	1.8436	1.7165	1.5734	19	17	16	15
0701	Fracture of lower extremity M >=61.50	1.2479	0.9654	0.9063	0.8402	10	10	10	9
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.5499	1.1991	1.1256	1.0435	12	12	12	11
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.9272	1.4910	1.3996	1.2975	15	15	14	13
0704	Fracture of lower extremity M <41.50	2.3801	1.8413	1.7285	1.6024	19	18	17	16
0801	Replacement of lower-extremity joint M >=63.50	1.2014	0.9657	0.8859	0.8405	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3629	1.0956	1.0050	0.9535	11	11	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.5045	1.2094	1.1094	1.0526	12	11	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.7129	1.3769	1.2630	1.1983	14	13	12	12
0805	Replacement of lower-extremity joint M <42.50	2.1019	1.6896	1.5499	1.4705	17	16	15	14
0901	Other orthopedic M >=63.50	1.2045	0.9344	0.8833	0.8185	10	10	9	9
0902	Other orthopedic M >=51.50 and M <63.50	1.5298	1.1867	1.1218	1.0396	12	12	11	11
0903	Other orthopedic M >=44.50 and M <51.50	1.8056	1.4007	1.3241	1.2270	14	13	13	13
0904	Other orthopedic M <44.5	2.1997	1.7064	1.6131	1.4947	17	16	16	15
1001	Amputation lower extremity M >=64.50	1.2128	1.0262	0.9176	0.8309	10	11	10	9
1002	Amputation lower extremity M >=55.50 and M <64.50	1.4950	1.2650	1.1312	1.0242	13	12	12	11
1003	Amputation lower extremity M >=47.50 and M <55.50	1.8265	1.5454	1.3820	1.2513	15	14	14	13
1004	Amputation lower extremity M <47.50	2.3300	1.9714	1.7629	1.5962	18	19	17	16
1101	Amputation non-lower extremity M >=58.50	1.2203	1.0195	1.0115	0.8957	10	11	11	9
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.5504	1.2952	1.2851	1.1380	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	1.9501	1.6292	1.6164	1.4314	18	15	16	12
1201	Osteoarthritis M >=61.50	1.1325	0.9930	0.9008	0.8454	10	10	9	9
1202	Osteoarthritis M >=49.50 and M <61.50	1.3995	1.2271	1.1132	1.0448	12	14	11	11
1203	Osteoarthritis M <49.50 and A >=74.50	1.8608	1.6317	1.4802	1.3892	15	16	15	14
1204	Osteoarthritis M <49.50 and A <74.50	1.8428	1.6158	1.4659	1.3757	15	15	15	13
1301	Rheumatoid other arthritis M >=62.50	1.1926	0.9161	0.9060	0.8269	10	7	9	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.5763	1.2108	1.1975	1.0929	13	12	11	11
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.8210	1.3988	1.3834	1.2626	15	14	13	13
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.2779	1.7497	1.7305	1.5793	16	18	16	15
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.1630	1.6614	1.6432	1.4996	16	15	16	15
1401	Cardiac M >=68.50	1.1232	0.9014	0.8241	0.7542	10	9	9	8
1402	Cardiac M >=55.50 and M <68.50	1.4297	1.1473	1.0490	0.9600	12	11	10	10
1403	Cardiac M >=45.50 and M <55.50	1.7420	1.3979	1.2781	1.1697	14	13	12	12
1404	Cardiac M <45.50	2.1238	1.7043	1.5583	1.4261	18	16	15	14
1501	Pulmonary M >=68.50	1.3315	1.0532	0.9963	0.9396	12	10	9	9
1502	Pulmonary M >=56.50 and M <68.50	1.6618	1.3145	1.2435	1.1727	13	12	11	11
1503	Pulmonary M >=45.50 and M <56.50	1.8975	1.5009	1.4199	1.3391	14	13	13	12
1504	Pulmonary M <45.50	2.3417	1.8523	1.7523	1.6526	20	16	15	15
1601	Pain syndrome M >=65.50	1.1604	0.8844	0.8055	0.7378	9	9	9	8
1602	Pain syndrome M >=58.50 and M <65.50	1.3988	1.0661	0.9710	0.8893	11	11	10	10
1603	Pain syndrome M >=43.50 and M <58.50	1.8072	1.3773	1.2545	1.1490	13	14	13	13
1604	Pain syndrome M <43.50	2.3376	1.7816	1.6226	1.4862	15	16	16	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.4118	1.0361	0.9599	0.8931	11	11	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.7470	1.2821	1.1878	1.1051	14	14	12	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	2.0375	1.4953	1.3853	1.2889	15	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.3316	1.7111	1.5852	1.4749	18	17	15	15
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.7785	2.0390	1.8890	1.7575	21	19	18	17

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
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.1369	0.9112	0.8488	0.7858	10	11	9	9
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.4359	1.1509	1.0720	0.9925	12	12	11	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.8201	1.4588	1.3589	1.2580	14	15	14	13
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	2.0490	1.6423	1.5297	1.4162	16	16	15	15
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.4949	1.9997	1.8627	1.7245	22	20	18	17
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.5322	2.8311	2.6371	2.4414	38	27	24	23
1901	Guillain-Barré M >=66.50	1.1076	0.9636	0.8527	0.8358	13	11	9	9
1902	Guillain-Barré M >=51.50 and M <66.50	1.5861	1.3798	1.2210	1.1969	18	15	13	12
1903	Guillain-Barré M >=38.50 and M <51.50	2.2925	1.9944	1.7648	1.7299	23	19	17	18
1904	Guillain-Barré M <38.50	3.4515	3.0026	2.6569	2.6045	37	29	25	25
2001	Miscellaneous M >=66.50	1.2086	0.9511	0.8750	0.8123	10	10	9	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4951	1.1765	1.0823	1.0048	12	11	11	10
2003	Miscellaneous M >=46.50 and M <55.50	1.7727	1.3950	1.2834	1.1914	14	14	13	12
2004	Miscellaneous M <46.50 and A >=77.50	2.1382	1.6825	1.5479	1.4370	17	16	15	15
2005	Miscellaneous M <46.50 and A <77.50	2.2758	1.7908	1.6475	1.5294	18	17	16	15
2101	Burns M >=52.50	1.5910	1.3048	1.2156	1.0359	11	15	13	11
2102	Burns M <52.50	2.4627	2.0198	1.8817	1.6035	14	20	18	15
5001	Short-stay cases, length of stay is 3 days or fewer	0.0000	0.0000	0.0000	0.1764	0	0	0	2
5101	Expired, orthopedic, length of stay is 13 days or fewer	0.0000	0.0000	0.0000	0.8614	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more	0.0000	0.0000	0.0000	1.9493	0	0	0	18
5103	Expired, not orthopedic, length of stay is 15 days or fewer	0.0000	0.0000	0.0000	0.9517	0	0	0	9
5104	Expired, not orthopedic, length of stay is 16 days or more	0.0000	0.0000	0.0000	2.2709	0	0	0	20

BILLING CODE 4120–01–C

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 propose to 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 proposed CMG relative weight revisions. However, the proposed 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	43	0.0%
Increased by between 5% and 15%	625	0.1%
Changed by less than 5%	465,349	99.4%
Decreased by between 5% and 15%	1,930	0.4%
Decreased by 15% or more	126	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 proposed revisions for FY 2027. The proposed 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.

V. 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 propose to update 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. Proposed FY 2027 Market Basket Update and Productivity Adjustment

1. Proposed FY 2027 Market Basket Update

For FY 2027 (that is, beginning October 1, 2026, and ending September 30, 2027), we propose 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 propose to use the same methodology described in the FY 2026 IRF PPS final rule (90 FR 37687 through 37691).

Consistent with historical practice, we propose 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. For this proposed rule, 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 is 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.[1] We also propose that if more recent data become available after the publication of the proposed rule and before the publication of the 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.

2. Proposed 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).[2] 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-*

[1] *https://www.spsglobal.com/en.*

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

rates-statistics/market-basket-research-and-information.

For this FY 2027 IRF PPS proposed rule, based on IGI's fourth quarter 2025 forecast, the 10-year moving average growth of TFP for FY 2027 is projected to be 0.8 percent. In accordance with section 1886(j)(3)(C) of the Act, we propose 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 propose 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 is 2.4 percent (3.2 percent market basket percentage increase reduced by the 0.8 percentage point productivity adjustment). Furthermore, we propose that if more recent data become available after the publication of the proposed rule and before the publication of the 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 the final rule.

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.[3] As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary proposes to update the IRF PPS payment rates for FY 2027 by the proposed IRF market basket update of 2.4 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 invite public comments on our proposals for the FY 2027 market basket percentage increase and productivity adjustment.

C. Proposed 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 propose 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 propose 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 is 70.8 percent. We propose 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 is 8.1 percent of the 2021-based IRF market basket for FY 2027, we propose 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 propose 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 propose that if more recent data subsequently become available after publication of the proposed rule and before the publication of the 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 the final rule.

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

[3] March 2026 Report to the Congress: Medicare Payment Policy.

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

	FY 2027 Proposed Labor-Related Share [1]	FY 2026 Final Labor-Related Share [2]
Wages and Salaries	49.5	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	**70.8**	**70.7**
Labor-related portion of Capital-Related (46%)	3.7	3.7
Total Labor-Related Share	**74.5**	**74.4**

[1] Based on the 4th quarter 2025 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.

We invite public comments on the proposed labor-related share for FY 2027.

D. Proposed 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 propose 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 proposed and finalized 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 are proposing to continue to use the concurrent pre-floor, pre-reclassified 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). At the same time, 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

[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.*

wage data to establish different weights for setting-specific occupational labor mixes as one approach to geographic adjustments.

We are soliciting comments on whether we should consider using alternative data sources to construct an IRF-specific wage index for potential use in future years. CMS seeks 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 seek feedback on the unique considerations applicable to IRFs that should inform how CMS considers the potential use of alternative data sources.

We invite 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.

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- revised 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 implementation 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. 1804 (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. As stated in the FY 2025 IRF PPS final rule (89 FR 64276), the purpose of this gradual phase-out of the rural adjustment for these facilities is to reduce the potential negative financial impacts associated with this reclassification. 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. This final step is part of a gradual reduction of the 14.9 percent rural adjustment over three fiscal years FYs 2025, 2026 and 2027. Furthermore, this policy does not apply to urban IRFs transitioning to rural status, as they will receive the full rural adjustment.

4. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed 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 (74.5 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. of this proposed 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/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

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 74.5 percent.

Step 3. Divide the amount calculated in Step 1 by the amount calculated in Step 2. The resulting quotient is the proposed FY 2027 budget-neutral wage adjustment factor of 1.0033.

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 proposed rule.

We invite public comments on our proposals regarding the wage adjustment for FY 2027.

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

To calculate the proposed 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 2.4 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 $19,836. 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 1.0033, which results in an IRF standard payment amount of $19,901. We next apply the budget neutrality factor for the CMG relative weights of 0.9990, which results in the proposed IRF standard payment conversion factor of $19,881 for FY 2027.

TABLE 5: Calculations to Determine the Proposed 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 2.4 percent*	x	1.0240
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
FY 2027 Standard Payment Conversion Factor	=	$19,881

*Reflects a FY 2027 3.2 percent IRF market basket percentage increase reduced by 0.8 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 rule to the proposed FY 2027 standard payment conversion factor ($19,881), 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.

BILLING CODE 4120–01–P

TABLE 6: Proposed FY 2027 IRF PPS Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 19,570.86	$ 16,793.48	$ 15,318.31	$ 14,694.05
0102	$ 24,926.80	$ 21,389.97	$ 19,511.21	$ 18,715.97
0103	$ 31,970.64	$ 27,433.79	$ 25,024.21	$ 24,004.32
0104	$ 40,439.94	$ 34,702.29	$ 31,652.54	$ 30,362.26
0105	$ 51,517.64	$ 44,207.39	$ 40,322.64	$ 38,680.47
0106	$ 58,732.45	$ 50,400.32	$ 45,970.84	$ 44,096.06
0201	$ 22,107.67	$ 17,542.99	$ 16,089.69	$ 15,085.70
0202	$ 27,274.74	$ 21,644.44	$ 19,849.19	$ 18,612.59
0203	$ 34,250.99	$ 27,179.32	$ 24,924.81	$ 23,372.10
0204	$ 42,388.28	$ 33,636.66	$ 30,847.36	$ 28,924.87
0205	$ 54,879.51	$ 43,549.33	$ 39,938.94	$ 37,449.84
0301	$ 24,411.88	$ 18,712.00	$ 17,562.88	$ 16,248.74
0302	$ 31,443.79	$ 24,101.74	$ 22,620.60	$ 20,930.72
0303	$ 38,141.70	$ 29,237.00	$ 27,439.76	$ 25,388.04
0304	$ 44,787.92	$ 34,330.51	$ 32,221.14	$ 29,811.56
0305	$ 48,551.39	$ 37,215.24	$ 34,928.93	$ 32,316.57
0401	$ 26,065.98	$ 22,417.82	$ 20,972.47	$ 19,127.51
0402	$ 32,517.36	$ 27,966.60	$ 26,163.40	$ 23,861.18
0403	$ 41,344.53	$ 35,557.17	$ 33,264.89	$ 30,338.41
0404	$ 61,660.92	$ 53,028.59	$ 49,613.04	$ 45,247.17
0405	$ 51,368.53	$ 44,177.57	$ 41,332.60	$ 37,694.38
0406	$ 63,708.66	$ 54,790.05	$ 51,261.17	$ 46,750.17
0407	$ 89,029.11	$ 76,565.71	$ 71,633.23	$ 65,328.97
0501	$ 25,288.63	$ 20,016.19	$ 18,791.52	$ 17,481.36
0502	$ 31,008.40	$ 24,543.09	$ 23,040.09	$ 21,433.71
0503	$ 35,008.45	$ 27,708.15	$ 26,012.30	$ 24,199.15
0504	$ 42,016.51	$ 33,254.95	$ 31,219.13	$ 29,042.16
0505	$ 58,813.96	$ 46,551.36	$ 43,700.43	$ 40,654.66
0601	$ 27,181.30	$ 19,906.85	$ 18,535.06	$ 16,990.30
0602	$ 33,823.55	$ 24,771.73	$ 23,063.95	$ 21,141.46
0603	$ 39,684.46	$ 29,064.03	$ 27,062.02	$ 24,805.52
0604	$ 50,044.45	$ 36,652.61	$ 34,125.74	$ 31,280.77
0701	$ 24,809.50	$ 19,193.12	$ 18,018.15	$ 16,704.02
0702	$ 30,813.56	$ 23,839.31	$ 22,378.05	$ 20,745.82
0703	$ 38,314.66	$ 29,642.57	$ 27,825.45	$ 25,795.60
0704	$ 47,318.77	$ 36,606.89	$ 34,364.31	$ 31,857.31
0801	$ 23,885.03	$ 19,199.08	$ 17,612.58	$ 16,709.98
0802	$ 27,095.81	$ 21,781.62	$ 19,980.41	$ 18,956.53
0803	$ 29,910.96	$ 24,044.08	$ 22,055.98	$ 20,926.74
0804	$ 34,054.16	$ 27,374.15	$ 25,109.70	$ 23,823.40
0805	$ 41,787.87	$ 33,590.94	$ 30,813.56	$ 29,235.01
0901	$ 23,946.66	$ 18,576.81	$ 17,560.89	$ 16,272.60
0902	$ 30,413.95	$ 23,592.78	$ 22,302.51	$ 20,668.29
0903	$ 35,897.13	$ 27,847.32	$ 26,324.43	$ 24,393.99
0904	$ 43,732.24	$ 33,924.94	$ 32,070.04	$ 29,716.13
1001	$ 24,111.68	$ 20,401.88	$ 18,242.81	$ 16,519.12
1002	$ 29,722.10	$ 25,149.47	$ 22,489.39	$ 20,362.12
1003	$ 36,312.65	$ 30,724.10	$ 27,475.54	$ 24,877.10
1004	$ 46,322.73	$ 39,193.40	$ 35,048.21	$ 31,734.05
1101	$ 24,260.78	$ 20,268.68	$ 20,109.63	$ 17,807.41
1102	$ 30,823.50	$ 25,749.87	$ 25,549.07	$ 22,624.58
1103	$ 38,769.94	$ 32,390.13	$ 32,135.65	$ 28,457.66
1201	$ 22,515.23	$ 19,741.83	$ 17,908.80	$ 16,807.40
1202	$ 27,823.46	$ 24,395.98	$ 22,131.53	$ 20,771.67

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1203	$ 36,994.56	$ 32,439.83	$ 29,427.86	$ 27,618.69
1204	$ 36,636.71	$ 32,123.72	$ 29,143.56	$ 27,350.29
1301	$ 23,710.08	$ 18,212.98	$ 18,012.19	$ 16,439.60
1302	$ 31,338.42	$ 24,071.91	$ 23,807.50	$ 21,727.94
1303	$ 36,203.30	$ 27,809.54	$ 27,503.38	$ 25,101.75
1304	$ 45,286.93	$ 34,785.79	$ 34,404.07	$ 31,398.06
1305	$ 43,002.60	$ 33,030.29	$ 32,668.46	$ 29,813.55
1401	$ 22,330.34	$ 17,920.73	$ 16,383.93	$ 14,994.25
1402	$ 28,423.87	$ 22,809.47	$ 20,855.17	$ 19,085.76
1403	$ 34,632.70	$ 27,791.65	$ 25,409.91	$ 23,254.81
1404	$ 42,223.27	$ 33,883.19	$ 30,980.56	$ 28,352.29
1501	$ 26,471.55	$ 20,938.67	$ 19,807.44	$ 18,680.19
1502	$ 33,038.25	$ 26,133.57	$ 24,722.02	$ 23,314.45
1503	$ 37,724.20	$ 29,839.39	$ 28,229.03	$ 26,622.65
1504	$ 46,555.34	$ 36,825.58	$ 34,837.48	$ 32,855.34
1601	$ 23,069.91	$ 17,582.76	$ 16,014.15	$ 14,668.20
1602	$ 27,809.54	$ 21,195.13	$ 19,304.45	$ 17,680.17
1603	$ 35,928.94	$ 27,382.10	$ 24,940.71	$ 22,843.27
1604	$ 46,473.83	$ 35,419.99	$ 32,258.91	$ 29,547.14
1701	$ 28,068.00	$ 20,598.70	$ 19,083.77	$ 17,755.72
1702	$ 34,732.11	$ 25,489.43	$ 23,614.65	$ 21,970.49
1703	$ 40,507.54	$ 29,728.06	$ 27,541.15	$ 25,624.62
1704	$ 46,354.54	$ 34,018.38	$ 31,515.36	$ 29,322.49
1705	$ 55,239.36	$ 40,537.36	$ 37,555.21	$ 34,940.86
1801	$ 22,602.71	$ 18,115.57	$ 16,874.99	$ 15,622.49
1802	$ 28,547.13	$ 22,881.04	$ 21,312.43	$ 19,731.89
1803	$ 36,185.41	$ 29,002.40	$ 27,016.29	$ 25,010.30
1804	$ 40,736.17	$ 32,650.57	$ 30,411.97	$ 28,155.47
1805	$ 49,601.11	$ 39,756.04	$ 37,032.34	$ 34,284.78
1806	$ 70,223.67	$ 56,285.10	$ 52,428.19	$ 48,537.47
1901	$ 22,020.20	$ 19,157.33	$ 16,952.53	$ 16,616.54
1902	$ 31,533.25	$ 27,431.80	$ 24,274.70	$ 23,795.57
1903	$ 45,577.19	$ 39,650.67	$ 35,085.99	$ 34,392.14
1904	$ 68,619.27	$ 59,694.69	$ 52,821.83	$ 51,780.06
2001	$ 24,028.18	$ 18,908.82	$ 17,395.88	$ 16,149.34
2002	$ 29,724.08	$ 23,390.00	$ 21,517.21	$ 19,976.43
2003	$ 35,243.05	$ 27,734.00	$ 25,515.28	$ 23,686.22
2004	$ 42,509.55	$ 33,449.78	$ 30,773.80	$ 28,569.00
2005	$ 45,245.18	$ 35,602.89	$ 32,753.95	$ 30,406.00
2101	$ 31,630.67	$ 25,940.73	$ 24,167.34	$ 20,594.73
2102	$ 48,960.94	$ 40,155.64	$ 37,410.08	$ 31,879.18
5001	$ -	$ -	$ -	$ 3,507.01
5101	$ -	$ -	$ -	$ 17,125.49
5102	$ -	$ -	$ -	$ 38,754.03
5103	$ -	$ -	$ -	$ 18,920.75
5104	$ -	$ -	$ -	$ 45,147.76

BILLING CODE 4120–01–C

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 proposed 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 0.8624, 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 0.9492, 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 (74.5 percent) described in section VI. of this proposed 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/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed 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 Proposed FY 2027 IRF Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		$30,362.26		$30,362.26
2	Labor-Related Share	X	0.745	X	0.745
3	Labor Portion of Payment	=	$22,619.88	=	$22,619.88
4	CBSA-Based Wage Index	X	0.8624	X	0.9492
5	Wage-Adjusted Amount	=	$19,507.39	=	$21,470.79
6	Non-Labor Amount	+	$7,742.38	+	$7,742.38
7	Wage-Adjusted Payment	=	$27,249.76	=	$29,213.17
8	Rural Adjustment	X	1.149	X	1.000
9	Wage- and Rural-Adjusted Payment	=	$31,309.98	=	$29,213.17
10	LIP Adjustment	X	1.0156	X	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	$31,798.41	=	$30,539.45
12	Wage- and Rural-Adjusted Payment		$31,309.98		$29,213.17
13	Teaching Status Adjustment	X	0	X	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,290.31
15	Wage-, Rural-, and LIP-Adjusted Payment	+	$31,798.41	+	$30,539.45
16	Total Adjusted Payment	=	$31,798.41	=	$32,829.76

Thus, the adjusted payment for Facility A would be $31,798.41 and the adjusted payment for Facility B would be $32,829.76.

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

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 propose 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 estimate the amount of FY 2027 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2025) and the proposed 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 estimate that IRF outlier payments as a percentage of total estimated payments will be approximately 2.6 percent in FY 2026. Therefore, we propose 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 are proposing the outlier threshold amount of $8,689 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2027.

We invite public comments on the proposed update to the IRF outlier threshold for FY 2027.

B. Proposed 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 propose 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 propose 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 propose 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 this 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 2023) 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 proposed rule, we estimate a national average CCR of 0.461 for rural IRFs and a national average CCR of 0.386 for urban IRFs.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we propose a national CCR ceiling of 1.54 for FY 2027. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.54 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 propose that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, we will 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 proposed rule, we estimate a national average CCR ceiling of 1.54, using the same methodology.

We invite public comments on the proposed update to the IRF CCR ceiling and urban/rural averages for FY 2027.

VII. Proposals To Revise the Basis of Payment Requirements

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

In accordance with 42 CFR 412.622(a)(3)(ii), 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 (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at

least 5 days per week. Under certain conditions, this program might consist of at least 15 hours of intensive rehabilitation therapy provided over 7 days. 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. Sub-regulatory guidance that was posted by CMS 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 (hereafter referred to as the 36-hour requirement). 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. 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 (that is, 36 hours after Tuesday at midnight).

For the purposes of this proposed rule, we are proposing to revise § 416.622(a)(3)(ii) to require all therapy treatments and/or therapy evaluations must begin no later than 36 hours after midnight of 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.

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

IRFs are required to document a comprehensive preadmission screening 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 preadmission screening 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 in order for an appropriate plan of care to be developed for a patient, a patient's *current* functional status must also be documented in the preadmission screening. 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.

For the purposes of this proposed rule, we are proposing to revise § 412.622(a)(4)(i)(B) to 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 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 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)). However, there has been guidance provided to IRFs that says the initial IDT meeting may occur on day 8 from the day of admission, which is not aligned with the current policy.

2. Proposed 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. For example, and under the current policy, 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 his/her progress. Per § 412.622(a)(4)(ii), an individualized overall POC must be developed by a rehabilitation physician with input from the interdisciplinary team within 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 interdisciplinary team 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 PT's 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 propose 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, we are proposing that a patient's subsequent IDT meetings occur weekly (for example, within 7 days from the prior IDT meeting). See Figure 1 and Table 8 for 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 propose 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 propose 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.

BILLING CODE 4120–01–P

Figure 1: Proposed Initial Interdisciplinary Team Meeting Policy

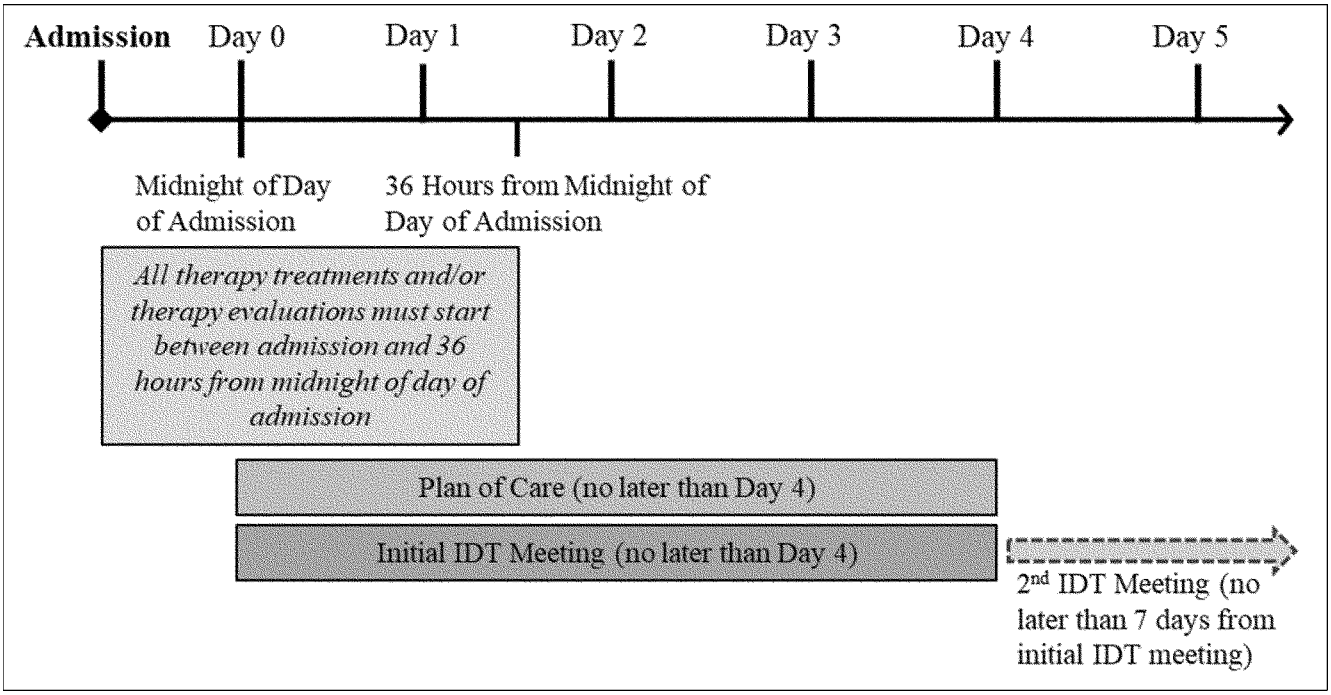

TABLE 8. Compliant and Non-Compliant IRF Patient Examples of IDT Timelines

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.

BILLING CODE 4120–01–C

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 this proposal, 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 approximated 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.

VIII. Request for Information Regarding Future IRF Payment Reform

CMS is exploring opportunities to modernize the IRF Prospective Payment System (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 groupings. Below, we provide an overview of the current IRF PPS patient classification system and request input on future payment reforms to enhance and modernize the IRF payment structure.

A. Background

Under the IRF PPS, providers report an Impairment Group Code (IGC) in Item 21A of the IRF Patient Assessment Instrument (IRF–PAI) to identify the primary reason the patient requires IRF care. Each IGC maps to a single Rehabilitation Impairment code (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 seek 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 proposed 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 are soliciting 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.*

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 are soliciting 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.*

IX. 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.

In this proposed rule, we are proposing to revise the IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP, as described in section IX.D.2 of this proposed rule. Finally, we are soliciting public comments on one RFI on future measure concepts for the IRF QRP in section IX.C. of this proposed rule.

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.

BILLING CODE 4120–01–P

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

BILLING CODE 4120–01–C

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.

We are seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advanced care planning. Advance care planning is a continuous process that supports people in understanding and communicating their goals, values, and preferences regarding future medical decisions.[5] The Patient Self Determination Act of 1990[6] supports this process by requiring healthcare facilities to inform patients of their rights regarding medical decisions, including advance directives and end of life care.[7] In-post acute care (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 advance care planning facilitates shared decision-making by documenting patient preferences and ensuring goal-concordant care throughout care transitions.[8]

As we review new measure concepts, we would prioritize evidence-based outcome measures that promote person-centered care practices. We are seeking input on the relevant aspects of advanced care planning and measures appropriate for the IRF setting.

[5] 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.*

[6] Public Law 101–508, § 4206, 4751.

[7] *https://www.congress.gov/bill/101st-congress/house-bill/4449. https://www.congress.gov/bill/101st-congress/house-bill/5835.*

[8] 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.

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. Proposal To 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.

For IRF–PAI assessment-based measures, in the FY 2016 IRF PPS final rule (80 FR 47122), we finalized submission deadlines for IRFs to submit their 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 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.[9]

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 to require data submission the 15th day of the second month after the end of the calendar quarter 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 timeframe 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) Proposal To Revise the IRF QRP Assessment Data Submission Deadline

Beginning with the FY 2029 IRF QRP, we are proposing 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 are proposing that IRFs would follow the deadlines presented in Table 12 for the FY 2029 IRF QRP. We are also proposing that similar calendar year data submission deadlines would apply to future years' payment determinations.

[9] IRF Listening Session: Revising the Transmission Schedule for the IRF–PAI. Available in the Downloads section on the IRF QRP Measures Information web page: *https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-measures-information.*

TABLE 12: Proposed 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) Proposal To Revise the CDC NHSN Data Submission Deadlines

Beginning with the FY 2029 IRF QRP, we are proposing 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 are proposing that IRFs would follow the deadlines presented in Table 13 for the FY 2029 IRF QRP. We are also proposing 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 revising the IRF QRP data submission deadline for IRF–PAI and CDC NHSN data to require IRFs to submit CDC NHSN data by the 15th day of the second month after the end of the calendar quarter 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 invite comment on this proposal to require that IRFs complete their data submissions 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 are not proposing any new policies regarding the public display of measure data in this 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).

X. Proposed 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 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(s) for the applicable CBA(s) will be forfeited and the Secretary will collect on the bid surety bond(s). 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 product category and 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 (see 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, we propose 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 is 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 propose 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 explore mail 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 nationwide mail-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 Proposed Regulation

At § 414.412(g)(2)(i)(H), we are proposing that for future rounds of the DMEPOS CBP, the bid surety bond amount would remain at $50,000, and we propose 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 propose under § 414.412(g)(2)(iii) that the bidding entity must obtain a bid surety bond of $100,000. Additionally, we propose 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 bid. We are soliciting comments on these proposals.

XI. 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 are soliciting public comments on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

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 IX.D.2 of this proposed rule, we are proposing to revise the data submission deadlines beginning with the FY 2029 IRF QRP. If finalized, this requirement would not result in additional collection burden for the IRF QRP or revisions to the currently approved IRF–PAI.

If you comment on this information collection, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received by the date and time specified in the **DATES** section of this rule.

XII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIII. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would update 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 proposed rule would 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 proposed rule proposes to adopt 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).

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 estimate the total impact of the policy updates described in this proposed rule by comparing the estimated payments in FY 2027 with those in FY 2026. This analysis results in an estimated $355 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.

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 proposed rule would only generate approximately $0.02 million annualized costs at a 7 percent discount rate, discounted relative to year 2024, over a perpetual time horizon. This proposed rule, if finalized as proposed, is not expected to be an E.O. 14192 regulatory action because it would not impose any more than de minimis regulatory costs.

C. 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 $9.0 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 million in total annual revenue. (For more details, see the Small Business Administration's final rule that set forth size standards for healthcare industries, at 65 FR 69432 and see *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.) We believe NAICS code 622310 (Specialty Hospitals, except Psychiatric and Substance Abuse) is a reasonable proxy for inpatient rehabilitation facilities (IRFs) for purposes of contextualizing industry structure where 40 percent of entities are small business (127 out of 327 entities) according to SUSB data.

According to the MedPAC 2026 Report to Congress,[10] 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 1,175 IRFs. We invite feedback regarding this assumption.

As shown in Table 14, according to the 2022 Economic Census, all Specialty (except Psychiatric and Substance Abuse) Hospitals earned approximately $59.7 billion, while the small entities earned approximately $1.73 billion in total. The regulatory review cost is $341 per entity. Table 15 presents the distribution of $355 million increase in total annualized monetized transfers from the Federal Government and States to IRF providers in FY2027.

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. This proposed rule, if finalized as proposed, would have impact on a substantial number of small businesses. But the impact should not be significant. Table 15 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 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.

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

TABLE 14: 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.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, 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 proposed 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 proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. As stated, this proposed 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 603 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 15, we estimate that the net revenue impact of this proposed rule on rural IRFs is to increase estimated payments by approximately 3.3 percent based on the data of the 127 rural units and 14 rural hospitals in our database of 1,175 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 proposed rule will not have a significant impact on the operations of a substantial number of small rural IRFs.

D. Detailed Economic Analysis

We have estimated the impact of the proposed rule. This proposed rule updates the IRF PPS rates contained in the FY 2026 IRF PPS final rule (90 FR 37678). Specifically, this proposed rule proposes updates to the CMG relative weights and ALOS values, the wage index, and the outlier threshold for high-cost cases. This proposed 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 proposed rule will be a net estimated increase of $355 million in payments to IRFs for FY 2027. The impact analysis in Table 14 of this proposed rule represents the projected effects of the proposed 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 proposing to implement the standard annual revisions described in this proposed rule (for example, the update to the wage index and market basket percentage increase used to adjust the Federal rates). We are also proposing to reduce 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 $355 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 $300 million. In addition, there is an estimated $55 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 $355 million from FY 2026 to FY 2027.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 15. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed 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 proposed 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 proposed 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 proposed 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 proposed change in estimated payments based on the FY 2027 payment changes relative to the estimated FY 2026 payments.

2. Description of Table 15

Table 15 shows the overall impact on the 1,175 IRFs included in the analysis. The next 12 rows of Table 15 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 1,034 IRFs located in urban areas included in our analysis. Among these, there are 644 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 539 for-profit IRFs. Among these, there are 500 IRFs in urban areas and 39 IRFs in rural areas. There are 541 non-profit IRFs. Among these, there are 457 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 15 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 proposed rule to the facility categories listed are shown in the columns of Table 15. 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 proposed rule for FY 2027 to our estimated payments per discharge in FY 2026.

The average estimated increase in payments for all IRFs is approximately 2.8 percent. This estimated net increase includes the effects of the IRF market basket update for FY 2027 of 2.4 percent, which is based on an IRF market basket percentage increase of 3.2 percent, less a 0.8 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.

BILLING CODE 4120–01–P

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]
(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

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2027 Labor-Related Share & FY 2027 Wage Index	CMG Weights	Total Percent Change [1]
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

[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.

BILLING CODE 4120–01–C

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 15.

For this 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 proposed rule from $10,141 in FY 2026 to $8,689 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 15) 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 15, 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 proposed rule, the FY 2027 labor-related share is 74.5 percent, 0.1 percentage point higher than the labor-related share for FY 2026.

In the aggregate, since these proposed 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 the largest increase in payments of 5.6 percent for rural IRFs in the New England region. We estimate the largest decrease in payments from the update to the wage index and labor-related share to be a 0.8 percent decrease for urban IRFs in the East South Central region.

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

In column 6 of Table 15, we present the effects of the proposed budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these proposed 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 IX.A. of this 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 IX.D.2. of this proposed rule, we are proposing to revise the data submission deadlines beginning with the FY 2029 IRF QRP. If finalized, this requirement would not result in additional collection burden for the IRF QRP.

7. DMEPOS Competitive Bidding Program

This rule proposes a change to 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 proposing to increase 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 how 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. 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.

E. Alternatives Considered

1. IRF PPS

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this proposed rule. As noted previously in this proposed 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 proposing to update the IRF prospective payments in this proposed rule by 2.4 percent (which equals the proposed 3.2 percent IRF market basket percentage increase for FY 2027 reduced by a proposed 0.8 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. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed 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 proposed rule. We also assume that each reviewer reads 100 percent of the rule.

Using the national median hourly wage data from the May 2024 BLS for Occupational Employment and Wage Statistics (OEWS) for medical and health service managers (SOC 11–9111), we estimate that the cost of reviewing this rule is $113.42 per hour, including other indirect costs and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it will take approximately 3 hours for the staff to review the proposed rule. For each reviewer of the rule, the estimated cost is $340.26 (3 hours × $113.42). Therefore, we estimated that the total cost of reviewing this regulation is $399,805.5 ($340.26 × 1,175 reviewers).

G. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf*), in Table 16, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of the proposed 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 proposed rule based on the data for IRFs in our database.

TABLE 16: 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	$355 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	$399,806

H. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2027 are projected to increase by 2.8 percent, compared with the estimated payments in FY 2026, as reflected in column 7 of Table 15.

IRF payments per discharge are estimated to increase by 2.8 percent in urban areas and 3.3 percent in rural areas, compared with estimated FY 2026 payments. Payments per discharge to rehabilitation units are estimated to increase 3.5 percent in urban areas and 3.4 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.5 percent in urban areas and 3.2 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this proposed rule. The largest payment increase is estimated to be 5.6 percent for IRFs in Rural New England. The analysis above, together with the remainder of this preamble, provides an RIA.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 31, 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 proposes to amend 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), (a)(4)(i)(B), 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, generally requires 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 the day of admission to the IRF.

* * * * *

(4) * * *

(i) * * *

(B) It includes 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, current functional status, the 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.

* * * * *

(5) * * *

(ii) The initial interdisciplinary team meeting must occur on or before the fourth day from midnight of 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 shall be used to determine the patient's subsequent team meetings. The remaining IDT 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.

[FR Doc. 2026–06642 Filed 4–2–26; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

45 CFR Part 261

RIN 0970–AD07

Work Participation Rate Calculation Changes: Recalibration of the Caseload Reduction Credit and Prohibition of Small Checks in Work Participation Rate Calculation

AGENCY: Office of Family Assistance (OFA), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: ACF proposes to make changes to the Temporary Assistance for Needy Families (TANF) program regulations to reset the base year of the caseload reduction credit from fiscal year (FY) 2005 to the new year established by Congress, which is currently FY 2015, and to exclude from the TANF work participation rate calculations certain cases that receive assistance payments benefits of less than $35 for a month. These changes are required by the Fiscal Responsibility Act (FRA) of 2023. The docket on *https://www.regulations.gov* will include a plain language summary of