Federation of American Hospitals®

Charles N. Kahn III
President and CEO

June 9, 2025

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program (CMS-1829-P)

Dear Dr. Oz,

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services ("CMS") regarding its Proposed Rule, Inpatient Rehabilitation Facility ("IRF") Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program ("Proposed Rule") published in the Federal Register on April 11, 2025. The FAH has submitted a separate letter outlining our response to the proposed rule's request for information on deregulation, specifically addressing the questions outlined in the Executive Order issued on January 31, 2025 entitled "Unleashing Prosperity Through Deregulation."

MARKET BASKET UPDATE

For FY 2026, CMS proposes to update the 2021-based IRF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2024 forecast with historical data through the 3rd quarter of 2024. Using that forecast, the proposed IRF market

basket for FY 2026 is 3.4 percent. Using data from the same period, CMS estimates an offset to the IRF market basket for productivity of 0.8 percentage points. Consequently, CMS proposes an IRF PPS update of 2.6 percent for FY 2026 for hospitals that submit quality data.

The FAH has serious concerns that the proposed market basket forecast has not accurately nor adequately captured the unique factors influencing the hospital and health care market today in general, and the market in which IRFs compete specifically. The scope and scale of the COVID-19 pandemic was unprecedented in our times with the constant barrage of challenges and pressures that hospitals faced significantly affecting their workforce and operations. Chronic, preexisting nurse and caregiver shortages exploded during the pandemic forcing hospitals to rely on more expensive contract labor than they have in the past.

Hospitals weathered an unrelenting cascade of market pressures during the COVID-19 public health emergency (PHE), compounded by historically high, spiraling inflation. These inflationary cost pressures for IRFs and all of America's hospitals were not captured in IGI's prior estimates of the market basket for FY 2021 through FY 2023. These concerns have been borne out by data released by the CMS' Office of the Actuary (OACT). The below table shows the market basket forecast used for the FY 2021 through FY 2024 IRF PPS update compared to the actual inflationary increase experienced by IRFs based on later data:

IRF Market Basket[1]	FY 2021	FY 2022	FY 2023	FY 2024
Forecast Used in the Update	2.4	2.6	4.2	3.6
Actual Based on Later Utilization	2.8	5.3	4.8	3.8
Difference	-0.4	-2.7	-0.6	-0.2

As this table reflects, market basket updates to IRFs between FY 2021 and FY 2024 underestimated the increase to base IRF rate by 3.9 percentage points. This means that the base rate for FY 2026 is at least 3.9 percentage points too low before updating IRF rates for FY 2026.

The FAH urges CMS to consider an adjustment for forecast error to ensure that the FY 2026 rate increase is applied to a base rate that more accurately incorporates actual inflation during the pandemic. While the FAH recognizes that CMS has not had a policy to incorporate forecast error into the IPF update, our request is based on the extraordinary understatement of the IRF market basket if FY 2022 and FY 2023 and a combined 3.9 percentage points over four years. IRF rates remain permanently too low and below the rate of increase in costs because of the understatement of the market basket for these years.

The FAH is further concerned that the IPF update for FY 2025 includes a reduction for non-farm productivity of 0.8 percent. The COVID-19 pandemic has had an unimaginable impact on US productivity and most estimates of labor productivity highlight uncharacteristic reductions. Even before the pandemic, OACT indicated that hospital productivity will be less than general economy wide productivity that is being used as an offset to the hospital market

[1]OACT, 4th quarter 2024 release of the market basket information with historical data through the 3rd quarter of 2024 (Market Basket Data | CMS) for the actual update based on later utilization.

baskets. In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital [productivity] using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business [productivity] of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[2]

While the annual productivity offset is based on a provision of the Affordable Care Act of 2010 and is required by law, the FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2026 IRF PPS update based on the understatement of the IRF PPS market basket baskets from FY 2021 to FY 2024 of 3.9 percentage points.

For these reasons, the FAH requests CMS adopt a forecast error adjustment to the FY 2025 IRF PPS update based on the 3.9 percentage point difference in the IRF PPS market basket for FY 2021 through FY 2024. Adopting our suggestion would make the market basket equal to 3.6 percent plus 3.9 percentage points less 0.8 percentage points or 6.7 percent. Considering this once-in-a-generation convergence of inflationary and COVID-19 pandemic forces, the FAH recommends CMS consider its update for IRF PPS payments to ensure that the FY 2026 rate corrects the understatement of past inflation and recognizes that OACT's own analysis concluding that hospitals cannot achieve the same productivity gains as the general economy. We urge CMS to consider its regulatory authority to modify this adjustment or make a PHE related exception in its application for the FY 2026 update.

CMG RELATIVE WEIGHTS AND AVERAL LENGTH OF STAY FOR FY 2023

CMS has proposed updates to Case-Mix Group ("CMG") relative weights and average length of stay values using fiscal years ("FY") 2024 IRF claims and 2023 IRF cost reporting data. **The FAH supports CMS' update to the CMG relative weights and average length of stay values for FY 2026 and encourages CMS to use the latest available data to update these in the Final Rule.**

WAGE INDEX

Consistent with past practice, CMS proposes to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2025 IPF wage index. Each wage index assigned to an IRF is based on the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the Core-Based Statistical Area (CBSAs) established by the OMB. Generally, OMB issues major revisions to statistical areas every 10

[2] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).

years, based on the results of the decennial census. On July 21, 2023, OMB issued Bulletin 23–01, which revises the CBSA delineations based on the latest available data from the 2020 census.

CMS is proposing to implement the new OMB delineations effective beginning with the FY 2025 IRF PPS wage index. As a result of the new proposed CBSA delineations, the proposed rule indicates that 8 providers are located in areas that were previously considered rural but would now be considered urban under the revised OMB delineations. CMS provides a 14.9 percent rural adjustment factor for IRFs located in a rural area.

For IRFs currently located in rural areas that are proposed to be urban under the new CBSA delineations, CMS proposes to phase-out the rural adjustment over three years in 1/3 increments. This policy would allow IRFs located in counties that are classified as rural in FY 2024 becoming urban in FY 2025 to receive two-thirds of the rural adjustment for FY 2025. For FY 2026, these IRFs would receive one-third of the rural adjustment. For FY 2027, these IRFs would not receive a rural adjustment. **The FAH supports CMS' proposal to phase-out the rural adjustment for rural IPFs becoming urban over three years.**

Changes to use the proposed CBSA delineations may change an IRF's wage index relative to using the current CBSA delineations. In the past, CMS has proposed a transition to new wage indexes based on the revised CBSA delineations. However, CMS no longer believes a transition is necessary as it adopted a 5 percent cap on reductions to an IRF's wage index in a single year beginning with FY 2023. CMS is not proposing a transition to the IRF wage index using the new CBSA delineations but will instead apply its current policy of limiting the single year reduction to a hospital's wage index to 5 percent.

The FAH appreciates CMS' recognition of how disruptive drops in the area wage index can create significant challenges for IPFs. For this reason, the FAH strongly supports a 5 percent stop-loss to minimize annual reductions in the area wage index value and to help mitigate wide annual swings that are beyond a hospital's ability to control. **The FAH urges CMS to adopt the 5 percent stop-loss in a non-budget neutral manner.**

The FAH appreciates CMS' much needed efforts to address the problems and financial challenges that rural hospitals face. CMS policy must ultimately ensure that Medicare payment formulas do not operate to magnify the stress on the rural health delivery system and contribute to access issues for Medicare beneficiaries living in rural areas. For the IPPS CMS has proposed to continue its policy of increasing the wage index values for hospitals with a wage index value in the lowest quartile of the wage index values across all hospitals. For hospitals in the lowest quartile, CMS has temporarily increased the hospital wage index values below the 25th percentile by half of the difference between the hospital's wage index value and the 25th percentile wage index value. The FAH encourages CMS to consider developing and applying a corresponding low wage index hospital policy for rural and low wage index IRFs to ensure that IRFs in low wage index and rural areas, which typically draw from the same labor pool as IPPS hospitals, have adequate resources to continue to provide access to care for vulnerable Medicare beneficiaries that need inpatient rehabilitation care. ***The FAH also urges CMS to implement this policy without applying a budget neutrality adjustment to the IPF PPS standardized amounts, as we believe such budget neutral adjustments are not required.***

The wage index values of the existing hospitals subject to the cap will continue to differ significantly from the currently published tables. Existing providers must refer to the rate-setting file to verify their correct wage index values to ensure the MACs are updating the correct values in the system. **We encourage CMS to release wage index tables in the Final Rule that incorporate the cap on CBSA's that meet the 5 percent decrease criteria, in order to avoid errors in the payment rates established by the Medicare Administrative Contractors ("MACs").**

HIGH-COST OUTLIERS

The outlier policy is an important component of the IRF PPS that helps ensure that payments for high-cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. However, we have concerns that outlier payments under the IRF PPS are not always targeted to patients who require more intensive services with related higher costs.

CMS estimates that IRF outlier payments, as a percentage of total estimated payments, would be approximately 2.8 percent in FY 2025, or 0.2 percentage points lower than the target of 3.0 percent. For FY 2026, CMS proposes to decrease the fixed loss threshold from $12,043 in FY 2025 to $11,971 in FY 2026. CMS will update the proposed outlier threshold in the final rule based on later data.

The FAH is concerned that outlier payments to providers have continued to be concentrated among an increasingly small number of providers. While outlier payments are important to help facilities with extremely costly cases, we are concerned that factors other than patient complexity and case mix may be driving these extra payments. To address this over reliance on outlier payments by some facilities, CMS may want to consider additional future policies such as a reconciliation process or possibly establishing a cap on an individual IRF's outlier payment (consistent to the outlier policy under the home health payment system).

The FAH supports the reduction in the outlier threshold and encourages CMS to further evaluate the variation in outlier spending by provider and consider including historical outlier reconciliation dollars in the outlier projections to ensure more accurate calibration of outlier payment amounts.

IRF QUALITY REPORTING PROGRAM ("QRP")

Proposed Removal of COVID-19 Vaccination Measures

CMS is proposing to remove two COVID-19-related measures from the IRF QRP: the *COVID-19 Vaccination Coverage Among Healthcare Personnel* measure beginning in FY 2026, and the *COVID-19 Percent of Patients Who Are Up to Date* measure beginning in FY 2028. CMS notes that IRFs will not be penalized for non-reporting of CY 2024 data related to these measures.

The FAH supports the removal of these measures. Given the end of the COVID-19 public health emergency and the growing difficulty of collecting accurate patient and staff vaccination status, we agree that these measures no longer provide meaningful information about facility quality. We also note that potential vaccine side effects, such as fatigue or fever, may interfere with patients' ability to participate in therapy during the short, intensive IRF stay. Removing these measures under Removal Factor 8 is appropriate, and we urge CMS to finalize their removal as proposed.

Proposed Removal of Select SPADES Items

CMS is proposing to remove four Social Determinants of Health (SDOH) Standardized Patient Assessment Data Elements **(**SPADES) from the IRF-PAI: Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330), scheduled to begin collection for discharges on or after October 1, 2026.

The FAH supports the removal of these SPADES items. These data elements are not currently used in any quality measures or risk adjustment models, and their collection imposes unnecessary documentation burden on IRFs. Many hospitals already screen for social needs as part of standard discharge planning. Removing these items will streamline reporting while preserving patient-centered care.

Future IRF QRP Measure Concepts – Request for Information

CMS has requested feedback on several measure concepts under consideration for future inclusion in the IRF QRP, including interoperability, well-being, nutrition, and delirium. The FAH supports meaningful innovation in quality measurement and offers the following perspectives.

Interoperability

CMS is considering a measure to assess interoperability in the IRF setting. The FAH supports a narrowly defined, standards-based measure that aligns with the Promoting Interoperability Program. Many IRFs already exchange health data through certified EHRs and HIEs. CMS should avoid duplicating existing requirements and ensure any interoperability measure reflects current practice and technological variability across providers.

Well-Being

The FAH supports patient-centered care and agrees that promoting overall well-being is an important goal of rehabilitation. However, measures in this domain must be rigorously validated, feasible to collect, and sensitive to the IRF setting's short length of stay. Broad constructs such as life satisfaction or emotional well-being are challenging to measure reliably and may not reflect the core functional recovery that IRFs are designed to deliver. We urge CMS to proceed cautiously and prioritize measures with high clinical relevance and minimal burden.

Nutrition

CMS is evaluating a nutrition-focused measure concept. Most IRFs already screen for malnutrition using validated tools and incorporate dietitians into the care team. Any new measure should build on these existing practices, avoid duplication, and be designed to capture meaningful variation in care processes or outcomes. Interdisciplinary responsibility for nutrition should also be acknowledged in measure attribution.

Delirium

The FAH does not support a delirium measure in the IRF QRP at this time. The prevalence of delirium in the IRF population is significantly lower than in SNFs or LTCHs due to clinical stability requirements for admission. A measure in this domain would have limited utility and could introduce confusion. If CMS proceeds, we recommend using existing IRF-PAI items and focusing on symptom trajectory (i.e., improvement from admission to discharge) rather than presence alone.

Potential future revisions under consideration for the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) - Request for Information (RFI)

Considerations for a Pediatric-Specific IRF-PAI Instrument

CMS is seeking feedback on whether to develop a pediatric-specific version of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), citing the forthcoming requirement that IRFs collect the IRF-PAI on all patients regardless of payer beginning October 1, 2024. This expansion includes patients covered by non-Medicare payers, including pediatric populations.

The FAH does not support the development of a separate pediatric IRF-PAI assessment. Creating an additional version of the IRF-PAI would introduce unnecessary administrative complexity and confusion, especially given the technical challenges already associated with collecting and submitting this instrument across payer types. Rather than building a new tool, we urge CMS to incorporate intelligent skip logic into the existing IRF-PAI to accommodate pediatric patients. Many of the questions on the current instrument—particularly those related to sensitive mental health topics—are inappropriate or irrelevant for younger populations. Skip logic based on age would allow for more clinically appropriate, individualized assessments that reflect a patient's physical, cognitive, and emotional development, while preserving the integrity and comparability of the dataset. This approach would reduce burden while still allowing CMS to capture meaningful information for quality reporting.

Revising IRF-PAI Logic for Walking vs. Wheelchair Mobility

CMS is also seeking feedback on ways to reduce burden and streamline IRF-PAI data collection more broadly. One area where clarification and adjustment are urgently needed involves how the IRF-PAI distinguishes between walking and wheelchair mobility for quality measurement.

Under current IRF-PAI logic, if a patient is unable to walk 10 feet at both admission and discharge, the patient is automatically assigned a "not attempted" code and is assessed using the wheelchair items (GG0170R and GG0170S). However, if a patient is able to walk 10 feet at either admission or discharge—even with maximal assistance—that patient is assigned to the "walking" pathway for quality measurement, regardless of whether walking is the most clinically appropriate or realistic discharge standard.

The FAH is concerned that this logic results in a misalignment between patient capabilities and how outcomes are evaluated. Patients who require significant assistance to walk a minimal distance in a controlled hospital setting may not be able to ambulate safely in their home or community. As a result, these patients are assessed using walking metrics, even when wheelchair mobility would be a more appropriate and functional goal. This undermines the validity of the outcome measure and penalizes IRFs whose patients do not demonstrate walking improvements, even though they may have made meaningful gains in wheelchair independence.

We urge CMS to revise the IRF-PAI to include a clinical judgment field that allows qualified rehabilitation clinicians—such as physical therapists—to determine whether a patient should be evaluated under walking or wheelchair mobility domains. This change would ensure that IRF outcome measures better reflect patient goals, clinical reality, and rehabilitation progress. Enabling licensed clinicians to designate the most functionally appropriate standard for quality measurement will enhance the fairness and relevance of IRF performance assessment, especially for patients with complex needs or mobility limitations.

Proposed Revision to IRF-PAI Submission Deadlines

CMS is considering reducing the data submission period for the IRF-PAI from 4.5 months to 45 days after the end of each quarter to enable more timely public reporting.

While the FAH agrees that shortening the lag between data submission and public reporting is a laudable goal, we recommend a 60-day submission window instead of 45 days. A two-month timeframe would simplify compliance by aligning deadlines to the end of calendar months and avoid confusion caused by mid-month cutoff dates. This modest adjustment would preserve CMS' goal of timelier reporting while promoting operational feasibility for IRFs.

Access to Patient-Level Data for Claims-Based Measures

CMS does not currently provide IRFs with patient-level data for claims-based quality measures such as *Medicare Spending Per Beneficiary (MSPB)* and *Potentially Preventable Readmissions*.

The FAH strongly urges CMS to provide timely, patient-level feedback to IRFs for all claims-based measures. The current practice of releasing only aggregate, hospital-level data limits providers' ability to identify performance drivers, conduct root cause analyses, and implement quality improvement interventions. Patient-level data—ideally delivered quarterly—would empower IRFs to take targeted actions to improve care and reduce disparities. Acute care hospitals in the Hospital IQR Program receive such data, and IRFs should receive the same level of transparency and analytic capability.

Advancing Digital Quality Measurement in the IRF QRP – Request for Information

CMS seeks feedback on the use of FHIR®-based APIs and certified health IT systems to support digital quality measurement (dQMs) in IRFs.

The FAH supports CMS' vision of a more connected, interoperable quality reporting infrastructure. However, many IRFs face technical and financial barriers to adopting new technologies. CMS should provide robust technical assistance, clear implementation guides, and reasonable timelines for any new dQM requirements. Standardization of terminology (e.g., SNOMED, LOINC, ICD), alignment with ONC-certified EHR capabilities, and flexibility in reporting modalities will be essential to success. We also recommend CMS collaborate with QIOs and vendors to build capacity and reduce disparities in digital readiness across IRFs.

Challenges with NHSN Reporting Infrastructure

The current structure of the CDC's National Healthcare Safety Network (NHSN) was developed for voluntary reporting and has not evolved adequately to support mandatory QRP reporting. As a result, IRFs face unnecessary burden, reporting errors, and compliance risks.

The FAH recommends several key improvements:

- **Automated Reporting**: CDC should ensure that all data elements required by CMS can be submitted via CDA or CSV. Requiring manual data entry for specific fields—such as the "no IPF unit" checkbox or "no CAUTI" indicator—places undue burden on IRFs.

- **Group Upload Functionality**: IRFs should be allowed to use CSV uploads through the NHSN Group function to streamline submissions across facilities. Currently, rehabilitation hospitals are excluded from this capability.

- **Monthly Reporting Plan Requirement**: This legacy requirement should be eliminated. It creates unnecessary work and can trigger noncompliance if not completed—even when all required data are submitted. CMS and CDC should rely on facility type-based logic to determine reporting expectations.

- **Report Accuracy for New Facilities**: Newly opened IRFs are excluded from CAUTI CMS Reports due to delays in generating Standardized Infection Ratios (SIRs), even if they meet all reporting requirements. CMS should ensure that NHSN reports reflect actual data submission, not just SIR generation, to accurately assess QRP compliance.

- **Infrastructure Modernization**: CDC should modernize NHSN to align with the CMS QRP's mandatory reporting needs and ensure that burden-reducing efficiencies are equitably implemented across all provider types, including IRFs.

The FAH appreciates CMS' continued efforts to strengthen the IRF Quality Reporting Program while also considering opportunities to reduce provider burden and enhance data utility. As CMS contemplates future measure development, digital reporting modernization, and refinements to the IRF-PAI, we urge the Agency to prioritize feasibility, clinical relevance, and alignment with real-world practice.

We encourage CMS to engage stakeholders early in the development process and to adopt policies that support high-quality, person-centered care without introducing undue administrative complexity. The FAH remains committed to working collaboratively with CMS to ensure the IRF QRP evolves in a way that meaningfully informs quality improvement, preserves access to rehabilitative care, and reflects the unique role of IRFs in the post-acute continuum.

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The FAH appreciates the opportunity to offer comments on the FY 2026 IRF PPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,