Federation of American Hospitals

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President and CEO

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Via electronic submission at *http://www.regulations.gov*

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 2027 and Updates to the IRF Quality Reporting Program (CMS-1845-P)

Dear Dr. Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Proposed Rule for Federal Fiscal Year 2027. FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States and our members include inpatient rehabilitation hospitals and units that serve Medicare and Medicaid beneficiaries with complex rehabilitation needs in both urban and rural communities.

Inpatient rehabilitation facilities (IRFs) play a unique and essential role in the continuum of care. They provide intensive, hospital-level rehabilitation services for patients recovering from stroke, traumatic brain and spinal cord injuries, major trauma, and other serious conditions. The goal of this care is to help patients regain function and independence and return home whenever possible, rather than requiring ongoing care in a nursing facility or other lower-intensity setting.

FAH supports the Administration's focus on promoting patient independence, reducing avoidable institutional care, easing unnecessary regulatory burden, and ensuring that Medicare payment policy is grounded in sound data and thoughtful analysis. IRFs are critical to advancing each of these goals.

The comments and recommendations below are intended to support those shared objectives. We encourage CMS to ensure that IRF payment policies accurately reflect the costs of caring for medically complex rehabilitation patients, that new coverage and documentation requirements are clear and operationally workable before implementation, and that any significant changes to the IRF payment system are supported by robust analysis and informed by meaningful engagement with the clinicians and providers delivering this care. Where we raise concerns, we do so not to oppose modernization, but to help ensure that policy changes are appropriately targeted, operationally feasible, and implemented in a way that protects patient access to high-quality rehabilitation services.

EXECUTIVE SUMMARY

The Proposed Rule includes a number of substantive policy changes for FY 2027, several of which warrant additional clarification, analysis or refinement before they are finalized, and we urge CMS to make the following changes to achieve those goals without disrupting access to care for the complex patients IRFs serve. In summary:

FAH urges CMS to refine and delay two of the three proposed changes to the basis of payment requirements—the 36-hour rule and the preadmission screening —and withdraw the third requiring an interdisciplinary team meeting by Day 4. These coverage and documentation changes are operationally significant but, as drafted, lack the clarity MACs and IRFs need to apply them consistently. FAH details several important changes to improve the clarity of the proposed changes to the 36-hour rule and preadmission screening. FAH urges CMS to withdraw the proposed Day 4 timing for the initial team meeting, which would convert a progress-review meeting into a premature administrative procedural step and divert clinicians from direct patient care. Lastly, we ask CMS to move forward only after education has occurred and we request a minimum one-year delay of the current October 1, 2026 effective date so that technical claim denials unrelated to medical appropriateness are avoided.

FAH urges CMS to ensure the FY 2027 market basket update reflects the actual cost pressures IRFs face and to reexamine whether the productivity adjustment is consistent with the agency's own findings on hospital sector productivity. The proposed 2.4 percent net update is lower than the update finalized for FY 2026 and falls below current inflation, even as workforce, drug and supply costs continue to rise. FAH urges CMS to review whether the forecast adequately captures recent inflation volatility and to work with the Office of the Actuary and Congress to align the productivity adjustment with documented hospital-sector productivity rather than an economy-wide measure.

FAH supports the proposed reduction in the outlier threshold and urges CMS to conduct and publish a provider-level analysis of outlier spending before considering any future structural change to the outlier policy. The outlier policy is an essential safeguard for high-cost patients and for specialized programs—including cancer and transplant rehabilitation—that are not fully recognized in the current case-mix structure and rely on outlier support to remain viable. A preliminary review of the public rate-setting data raises questions about how outlier dollars are distributed and about the year-to-year volatility of the threshold. FAH encourages CMS to examine these questions and outlines several potential policy levers for future consideration, but urges that any structural change rest on published analysis and protect access for the specialized programs that depend on this policy.

FAH urges CMS to complete the foundational analysis and stakeholder engagement that should precede any redesign of the IRF PPS before advancing a PDPM-style classification approach in future rulemaking. FAH appreciates CMS' interest in modernization but is concerned that the RFI presents a specific PDPM-style structure before CMS has identified the goals for reform.

FAH urges CMS to retain the IPPS hospital wage index as the basis for the IRF wage index and to apply the 5 percent cap on a non-budget-neutral basis. IRFs compete for clinical staff in the same hospital-grade labor markets as acute care hospitals, making the IPPS wage index a more accurate measure of IRF labor costs than Bureau of Labor Statistics occupational survey data. FAH therefore does not support replacing the current methodology with BLS data and continues to recommend that the 5 percent cap protecting providers from disruptive wage index decreases be applied without penalizing IRFs in stable markets.

FAH supports more timely quality reporting but urges CMS to address underlying data-system infrastructure before shortening the IRF QRP submission deadline, and to engage IRF clinicians on any advance care planning measure. FAH does not object in principle to a shorter submission timeline but is concerned that current systems do not yet provide the real-time error feedback and technical support IRFs—particularly hospital-based units—would need to comply, and urges CMS to ensure that infrastructure is in place before the deadline takes effect. FAH supports the concept of advance care planning measurement, subject to IRF-specific design considerations, and urges CMS to engage IRF clinicians before any measure is proposed.

CONCLUSION

FAH appreciates the opportunity to comment on the FY 2027 IRF PPS Proposed Rule. If you have any questions or would like to discuss further, please do not hesitate to contact Alyssa Keefe, SVP Head of Policy at akeefe@fah.org or (202) 624-1500.

Sincerely,

/s/
Charlene MacDonald
President and CEO

APPENDIX A
FFY 2027 Inpatient Rehabilitation Facility Proposed Rule Comments

I. PROPOSED UPDATE TO THE IRF PPS FOR FY 2027 (Part V)

A. Market Basket Update and Productivity Adjustment (Part V.B)

For FY 2027, CMS proposes to update the 2021-based IRF market basket using IHS Global Inc.'s ("IGI") fourth-quarter 2025 forecast with historical data through the third quarter of 2025. Using that forecast, the proposed IRF market basket update for FY 2027 is 3.2 percent. Using data from the same period, CMS estimates an offset for productivity of 0.8 percentage points, resulting in a proposed IRF PPS update of 2.4 percent for FY 2027 for IRFs that submit quality data.

The current proposed update does not fully reflect the cost pressures IRFs continue to face and we urge CMS to reconsider. In fact, the proposed 2.4 percent net update is lower than the 2.6 percent net update finalized for FY 2026, even as workforce, supply, capital and operational cost pressures that have defined hospital economics since the COVID-19 public health emergency ("PHE") continue. The inadequacy of the proposed 2.4 percent update is underscored by current inflation data. According to the Bureau of Labor Statistics, the all-items Consumer Price Index ("CPI") rose 3.8 percent over the 12 months ending April 2026, leaving the proposed update 1.4 percentage points below overall inflation.[i] The CPI measures a different set of goods and services than the IRF market basket, but the rapid changes in the CPI in recent months indicate that we are entering a period of rapid inflation that should also impact the IRF market basket in FY 2027 in ways that could not be reflected in IGI's forecast due to reliance on 2025 data.

Preexisting nurse and caregiver shortages that worsened during the pandemic have not abated. The specialized clinical workforce upon which IRFs depend, including rehabilitation physicians, physical therapists, occupational therapists, speech-language pathologists and rehabilitation nurses, commands compensation that has risen faster than the broader economic indicators on which market basket forecasts depend. Further, total hospital expenses grew 7.5 percent in 2025 — more than twice the rate of growth in hospital reimbursement — driven by a 13.6 percent increase in drug expenses and a 9.9 percent increase in supply expenses, underscoring the structural gap between rising input costs and the proposed payment update.[ii] **The FAH urges CMS to carefully review inflation trends in light of recent growth and projected volatility so as to avoid a significant understatement of market-basket changes in FY 2027, much like occurred in FY 2022.** In that year, IGI's forecast and the finalized IRF market basket percentage significantly understated the actual percentage increase in the IRF market basket by 2.7 percent. This was the most significant market basket error going back to 2010 (the first year with historical data available) and the only instance where the difference between the projected and actual market basket for a year exceeded 1.5 percent. With early economic indicators suggesting a period of significant inflation and continued health care worker shortages, FAH strongly urges CMS to carefully consider whether the IGI's forecast adequately captures volatile market indicators when projecting the FY 2027 IRF market basket.

FAH is further concerned that the productivity adjustment continues to rely on an economy-wide total factor productivity measure that overstates the productivity gains achievable in the hospital sector. In a June 2, 2022 memorandum, the CMS Office of the Actuary (OACT) concluded that, over the period 1990 through 2019, the average growth rate of hospital productivity ranged from 0.2 percent to 0.5 percent, compared with average growth in private nonfarm business productivity of 0.8 percent. OACT further indicated that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable, compared with an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent. CMS proposes a 0.8 percentage point productivity offset for FY 2027, which is roughly double the rate OACT has identified as reasonable for the hospital sector. Every year the productivity adjustment is set at a level the hospital sector cannot achieve, the IRF PPS base rate moves further away from the cost reality IRFs face.

FAH recognizes that the productivity adjustment is required by section 1886(j)(3)(C)(ii)(I) of the Social Security Act, and that the statute does not provide CMS unilateral authority to set the adjustment at zero. The statute does not, however, require CMS to disregard the documented mismatch between the offset and OACT's own analysis of hospital sector productivity. **FAH urges CMS to work with Congress to modify the statute to focus on adjustments based on productivity changes in hospitals rather than private nonfarm businesses. We also urge CMS to engage OACT and the relevant offices within the Department of Health and Human Services in**

reexamining whether the methodology currently used to compute the productivity adjustment is consistent with the agency's own analytical findings about hospital sector productivity.

Taken together, the proposed 3.2 percent gross market basket update and the 0.8 percentage point productivity offset do not keep pace with the inflationary cost pressures IRFs continue to confront. FAH urges CMS to use the tools available within its statutory authority to ensure that the FY 2027 IRF PPS update more accurately reflects the cost environment in which IRFs are operating and the cost pressures that have not abated since the PHE.

B. Wage Index, Labor-Related Share and Related Adjustments (Part V.D)

Consistent with past practice, CMS proposes to use the FY 2025 pre-floor, pre-reclassified Inpatient Prospective Payment System (IPPS) hospital wage index as the basis for the FY 2027 IRF wage index, applied in a budget-neutral manner. CMS also proposes a labor-related share of 74.5 percent for FY 2027, to apply the third and final year of the rural-to-urban phase-out for IRFs reclassified under the revised Office of Management & Budget (OMB) delineations, and to continue applying the permanent 5 percent cap on annual wage index decreases.

1. Permanent 5 Percent Cap on Wage Index Decreases (Part V.D.5.)

FAH supports the continued application of the permanent 5 percent cap on annual wage index decreases. The cap helps mitigate disruptive year-over-year payment swings that are beyond a hospital's control and is particularly important for IRFs serving communities in which CBSA reconfigurations, IPPS hospital closures, or shifts in cost report data can produce wage index movements unrelated to the actual labor costs facing IRFs.

However, FAH again urges CMS to apply the cap on a ***non***-budget-neutral basis. When the cap is applied budget-neutrally, the cost of protecting providers from large wage index decreases is borne by all other IRFs, which undermines the protective intent of the policy and effectively penalizes IRFs in stable wage index markets for protections extended to IRFs in markets experiencing disruption. FAH does not believe that section 1886(j) of the Act requires this adjustment to be applied on a budget-neutral basis, and we urge CMS to revisit this position in the Final Rule.

In addition, FAH again requests that CMS release wage index tables in the Final Rule that incorporate the application of the 5 percent cap for core-based statistical areas (CBSAs) that meet the criteria, in order to reduce errors in payment rates established by the Medicare Administrative Contractors ("MACs"). Existing providers must currently refer to the rate-setting file to verify their correct wage index values, which creates administrative burden and risk.

2. Rural-to-Urban Phase-Out (Part V)

FY 2027 is the third and final year of the rural-to-urban phase-out for IRFs reclassified under the revised OMB delineations. FAH continues to support this phased approach and appreciates CMS' implementation of the policy in a manner that has allowed affected IRFs to predictably transition to this change over three years.

C. RFI on Alternative Wage Index Data Sources (Part V.E)

CMS solicits comment on alternative data sources for the IRF wage index, including the use of Bureau of Labor Statistics ("BLS") occupational wage data in place of the IPPS hospital wage index currently used. CMS notes that an analogous transition was finalized for the End Stage Renal Disease (ESRD) wage index in the CY 2025 ESRD PPS final rule and that the Medicare Payment Advisory Commission ("MedPAC") has recommended using county-level BLS wage data combined with payment-system-specific occupational mix.

FAH opposes replacing the current IPPS hospital wage index with BLS occupational wage data as the basis for the IRF wage index. IRFs compete directly with general acute care hospitals for the clinical workforce, including rehabilitation physicians, nurses, therapists and other specialized clinical staff, because both settings draw from the same hospital-grade labor pool. The IPPS hospital wage index, which is constructed from actual hospital wages and benefits reported on Medicare cost reports, more accurately reflects the labor costs that IRFs face in their local markets. The BLS Occupational Employment and Wage Statistics ("OEWS") data, by contrast, are not constructed for the purpose of measuring hospital-sector wages and have several characteristics that make them less suitable as a basis for the IRF wage index.

BLS data are not setting-specific. OEWS reports occupational wages across all employers within an industry, not within hospital settings specifically. The same nurse occupation code captures wages paid by hospitals, ambulatory surgery centers, dialysis facilities and other settings, blending wage levels that do not reflect the hospital-grade compensation IRFs must offer to recruit and retain clinical staff. BLS data also exclude benefits. OEWS captures wages only and does not include the cost of benefits that constitute a substantial share of hospital labor compensation; the IPPS hospital wage index, in contrast, is built from total wage and benefit costs reported on Medicare cost report. BLS data are subject

to survey-based volatility from sampling variation, reporting lags and revisions that reduce payment stability and predictability, and they are not subject to provider-level Medicare audit and verification standards in the way Medicare cost report data are. Finally, the geographic granularity of BLS aggregations, whether at the MSA, county or state level, does not necessarily match the labor markets IRFs actually draw from, which mirror the markets faced by IPPS hospitals competing for the same staff and are well captured by the CBSA-level wage data already underlying the IPPS wage index.

The ESRD precedent is not directly applicable. The ESRD setting has a different labor profile from the IRF setting, with a smaller share of acute hospital-grade clinical staff and a wage structure that lends itself more readily to occupational survey data. The rationale CMS articulated for transitioning the ESRD wage index to BLS occupational data does not transfer to the IRF setting that draws from the same labor pool as the IPPS hospitals whose wage data already underpin the existing IRF wage index. FAH also notes that an IRF-specific application of BLS data would face additional structural problems: the IRF cost report sample is substantially smaller than the IPPS sample, which raises concerns about CBSA-level statistical reliability, and many CBSAs would have only one or two reporting IRFs, creating volatility and confidentiality issues. Many of those IRFs are units of acute care hospitals for which the host hospital's IPPS wage index is the most appropriate measure of local labor costs. Further complicating the use of IRF cost report data is the fact that most IRFs do not report wage data in the same detail that IPPS hospitals traditionally do because it is not required. Accordingly, the use of IRF cost report data would first require IRF providers to reliably and accurately report several years of data in order to build a useable base of data.

For these reasons, FAH urges CMS to retain the IPPS hospital wage index as the basis for the IRF wage index. To the extent CMS is interested in refining the existing wage index, FAH believes that effort is better directed toward the policy issues raised elsewhere in this letter, specifically applying the 5 percent cap on a non-budget-neutral basis and adopting a low wage index hospital policy for IRFs analogous to the IPPS policy.

II. HIGH-COST OUTLIER PAYMENTS (Part VI)

For FY 2027, CMS proposes to decrease the fixed-loss outlier threshold from $10,141 in FY 2026 to $8,689 in FY 2027 to maintain estimated outlier payments at 3.0 percent of total estimated IRF payments. CMS also proposes the standard annual updates to the cost-to-charge ratio ("CCR") ceiling and the urban and rural average CCRs.

The outlier policy is an important component of the IRF PPS that helps ensure payments for high-cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. FAH supports CMS' proposed reduction in the outlier threshold and the proposed updates to the CCR ceiling and average CCRs.

However, FAH is concerned that outlier payments under the IRF PPS continue to vary from year to year. Outlier payments should be targeted to patients who require the most intensive services so that patient access to IRF care continues to be preserved. A preliminary review of the publicly available IRF rate-setting data raises important questions about whether outlier dollars are being distributed in a manner consistent with the policy's intended purpose and whether aspects of the current methodology may be contributing to year-to-year payment volatility for IRFs. The data suggest that outlier payments may be concentrated among a relatively small number of facilities, warranting further evaluation to better understand whether this reflects the legitimate needs of specialized high-cost programs or indicates broader targeting concerns. In addition, the annual recalibration of the fixed-loss threshold to achieve a single-year target may contribute to fluctuations in payments across years.

Given these dynamics, FAH encourages CMS to undertake a more detailed analysis of the drivers of outlier payment fluctuations and concentration patterns before considering structural policy changes. Such an analysis could help CMS better understand the extent to which factors such as reconciliation dollars, atypical-cost facilities, case-mix differences, and other methodological considerations affect the calculation of the fixed-loss threshold and the overall distribution of outlier payments across the field.

At the same time, the outlier policy plays an important role in preserving access for IRFs that serve highly specialized patient populations, including cancer rehabilitation, transplant rehabilitation and other small, specialized programs whose patients are not adequately recognized in the current Case Mix Group (CMG) structure and that would not be financially viable without outlier support. Any policy response to the concern with concentration of outlier payments to a small number of providers must therefore preserve access for these specialized programs. **FAH urges CMS to conduct and publish a provider-level analysis of outlier spending and, in future rulemaking, to evaluate the following non-mutually-exclusive policy levers.**

First, CMS could evaluate the outlier target on a three-year rolling average basis rather than recalibrating the fixed-loss threshold to a single-year 3 percent target. A three-year averaging approach would reduce the year-over-year threshold volatility that creates payment unpredictability for IRFs while preserving CMS' targeting discipline over time. Second, CMS could establish a per-IRF cap on the share of an IRF's Medicare payments that may come from the outlier pool, paired with an exemption pathway under which IRFs serving distinct, specialized populations (such as cancer rehabilitation, transplant rehabilitation or other small high-acuity programs) could apply for exclusion from the cap. A cap paired with an exemption pathway would address the concentration concern without compromising access for the specialized programs that legitimately rely on outlier payments. Third, CMS could exclude IRFs whose cost per day falls more than three standard deviations from the mean when calibrating the fixed-loss threshold, which would smooth the threshold calculation and limit the influence of a small number of facilities with atypical cost structures on payments to the broader field. Fourth, CMS should incorporate historical outlier reconciliation dollars in its outlier payment projections to ensure more accurate calibration of the threshold and CCRs over time.

FAH does not propose that CMS adopt any single one of these levers in the FY 2027 Final Rule. Rather, we urge CMS to conduct the underlying provider-level analysis, articulate the policy problem that targeting reform would address, and present the IRF community with a rationale and any specific policy proposals through future notice-and-comment rulemaking. Protecting access for specialized high-cost programs while addressing the concentration of outlier dollars among a small number of facilities requires an analytical foundation before any specific structural change is adopted.

III. PROPOSED CHANGES TO THE BASIS OF PAYMENT REQUIREMENTS (Part VII)

Section VII of the Proposed Rule contains three proposed amendments to the basis of payment requirements at 42 CFR § 412.622, each with a proposed effective date of October 1, 2026. FAH believes all of these changes are operationally significant, but lack the necessary clarity for implementation and use by MACs. While FAH's comments on each are below, if CMS ultimately decides to implement any of these proposed changes, it should do so on a delayed basis and only after CMS undertakes official industry outreach and education. A minimum one-year delay would give IRFs the opportunity to understand the new requirements and make operational, staffing, and other necessary adjustments. Finalizing these proposals with an October 1, 2026 effective date will result in an unnecessarily high volume of purely technical claim denials that have no connection to the underlying medical appropriateness of a patient to receive IRF care.

A. 36-Hour Rule, Initiation of Therapies Within 36 Hours of Admission (Part VII.A)

CMS proposes to revise 42 CFR § 412.622(a)(3)(ii) to clarify that all required therapy treatments and/or therapy evaluations ordered must begin no later than 36 hours from midnight on the day of admission to the IRF. CMS notes that this codification resolves ambiguity from prior sub-regulatory guidance about whether the 36-hour requirement applied to all prescribed therapies or only one.

FAH conditionally supports codification of the 36-hour requirement if CMS makes revisions the regulatory language to improve its clarity and precision. FAH urges CMS to incorporate the following clarifications into the regulatory text of the Final Rule.

The 36-hour requirement should apply only to therapies ordered by the rehabilitation physician (or other appropriately privileged clinician) upon or after the patient's admission to the IRF. Therapies identified in the preadmission screening are anticipated services, not physician orders, and should not constitute the specific therapies that must be initiated under the 36-hour rule. This clarification is needed because, in current Review Choice Demonstration ("RCD") practice, some contractors have applied the 36-hour requirement against therapies listed in the preadmission screening but that have not been ordered by the treating physician upon admission, producing denials in cases where the rehabilitation physician's post-admission orders were in fact initiated on time. Anchoring the regulatory text to physician orders, rather than to the preadmission screening, would address this issue directly. FAH also urges CMS to reinforce in the Final Rule preamble the longstanding principle that therapy cannot begin without a physician order.

Therapies ordered by a physician later in the stay should not be subject to a retroactive 36-hour countdown from admission. Clinical needs for additional therapy disciplines often emerge after admission as the patient progresses through the rehabilitation program. For instance, dysphagia commonly presents or worsens as patients increase nutritional intake during their stay, creating a clinical need for speech-language pathology services that was not present on admission. Similarly, spinal cord injury patients may have cognitive impairments that are not identified until rehabilitation activity reveals them, generating a need to order speech therapy several days into the stay. Existing regulations governing the interdisciplinary team conference permit the plan of care to be revised in response to changes in the patient's condition. Any revisions to the regulations pertaining to the 36-hour requirement should ensure that a

physician's judgment on when a patient needs a different type of therapy is not artificially restricted. The 36-hour requirement should not apply to the ordering of any therapy after initial compliance with this rule has been satisfied.

As the proposed rule notes, therapy evaluations should satisfy the 36-hour requirement. FAH supports CMS' position that therapy evaluations count toward initiation of therapy and urges CMS to confirm this in the regulatory text. Treatment begins with evaluation, and a contrary interpretation would discount the clinical services and patient participation in establishing the baseline against which therapy progress is measured.

To the extent the proposed new definition of the term "week" is intended to resolve sub-regulatory inconsistencies on a related timing question, FAH supports the addition of a regulatory definition. Finally, CMS should commit to issuing updated sub-regulatory guidance prior to the October 1, 2026 effective date so that MACs, RCD contractors, and IRFs share a common operational understanding of the codified requirement before unjustified audits and denials are predicated on an erroneous interpretation of the newly proposed regulatory text.

B. Preadmission Screening, Documentation of Current Functional Status (Part VII.B)

CMS proposes to revise 42 CFR § 412.622(a)(4)(i)(B) to require documentation of the patient's *current* functional status in the preadmission screening, in addition to the prior level of function already required.

FAH does not oppose the documentation of the patient's current functional status in the preadmission screening as an additional element supporting more accurate IRF admission determinations. **However, FAH urges CMS to confirm important clarifications in the Final Rule to ensure that the requirement is implemented in a manner consistent with the operational realities of the preadmission screening and does not create new compliance and audit risk for IRFs.**

First, the preadmission screening is a screening only, not a clinical assessment, and the documentation requirement should be calibrated accordingly. Preadmission screenings are typically completed by clinical liaisons, registered nurses, case managers, social workers and in some settings therapists, who rely on medical record review, observation and other screening-level information rather than on a hands-on functional evaluation. Many of the data points on current functional status originate from acute care hospital personnel during the IRF referral process. The required level of detail for documenting current functional status should be comparable to the existing prior-level-of-function requirement and should not require therapist-level functional evaluation or scoring of Section GG-style items, which are not feasible or clinically appropriate at the preadmission stage. FAH urges CMS to clarify in the Final Rule that documentation that is reasonable and consistent with industry practice, based on the information available to the clinician completing the screening, will satisfy the requirement.

Second, preadmission current-functional-status documentation should not be used as an audit comparison against the post-admission IRF Patient Assessment Instrument (IRF-PAI). The preadmission screening and the post-admission IRF-PAI are different instruments, completed by different clinicians, in different settings, using different sources of information and at different points in a patient's clinical trajectory. It is foreseeable, and clinically appropriate, that these documents will not align item for item. FAH urges CMS to confirm in the Final Rule that documented differences between current functional status as reported in the preadmission screening and as reported on the admission IRF-PAI will not be used as an audit comparison to allege upcoding, to deny admission as not reasonable and necessary, or to reduce CMG payment. Without that confirmation, this provision risks creating a new source of contractor-driven denials grounded in documentation-form discrepancies rather than the substance of a patient's clinical condition.

Third, CMS should provide implementation guidance and adequate lead time to IRF providers, optimally at least a year prior to implementation. FAH urges CMS to issue updated sub-regulatory guidance well in advance of the October 1, 2026 effective date, including confirmation that existing functional status information from referring providers suffices to describe a patient's current functional status. In addition, CMS should explicitly recognize in the final rule that Electronic Health Record (EHR) templates and preadmission form modifications take time to develop, validate, and deploy across multi-facility systems.

C. Initial Interdisciplinary Team Meeting by Day 4 of Admission (Part VII.C)

CMS proposes to revise 42 CFR § 412.622(a)(5)(ii) to require that the initial interdisciplinary team (IDT) meeting occur on or before the fourth day from midnight of the date the patient is admitted, aligned with the existing Individualized Overall Plan of Care (plan of care) timeframe. CMS also proposes that subsequent IDT meetings occur at least once per week after the date of the prior team meeting. CMS estimates an additional cost of approximately $399 per week per facility for IRFs that need to add or re-time IDT meetings.

FAH opposes the proposed Day 4 timing for the initial IDT meeting as overly prescriptive, inconsistent with how IRF care planning operates in practice, and likely to displace rather than improve the interdisciplinary care coordination that already occurs in IRFs. The proposal also relies on an internally inconsistent day-counting construct that conflicts with how the day of admission is treated elsewhere in IRF coverage and payment rules, and on a cost estimate that understates the operational impact of the change. **FAH, therefore, urges CMS to withdraw the Day 4 timing requirement from the Final Rule.**

The proposed Day 4 timing does not reflect the function of the initial IDT meeting in IRF care delivery. The individualized plan of care—the development of which this proposed change is presumed to support—is developed by the rehabilitation physician based on the patient's needs and initial response to therapy as well as the clinical documentation generated during the first several days of the IRF stay. The IDT meeting is most useful as a forum for the team to review the patient's progress against the established plan of care, to coordinate adjustments to the plan and to align on discharge planning. It is not intended to be a meeting at which the plan of care is created. Requiring the initial IDT meeting on or before Day 4, before the plan of care has been meaningfully informed by the patient's initial response to therapy, would convert what should be a progress-review meeting into a procedural step. This change also does not reflect the interdisciplinary coordination that already occurs in IRFs from the moment a patient is admitted, through daily bedside handoffs, real-time documentation in shared electronic health records, physician and therapy rounding, family engagement and case management discharge planning. The formal IDT meeting is one component of a broader interdisciplinary process; placing a regulatory premium on the timing of that single meeting risks displacing the ongoing coordination that drives care outcomes.

The principal operational cost of this proposal is not the dollar cost of additional clinician time, although that cost is also relevant; it is the diversion of clinical resources away from direct patient care. The proposed requirement would pull rehabilitation physicians, rehabilitation nurses, physical therapists, occupational therapists, speech-language pathologists and social workers away from the bedside to attend an additional formal meeting earlier in each patient's stay. For patients whose stays are short, this means a portion of the available hands-on therapy time would be redirected to a meeting that cannot meaningfully inform the plan of care because, in some instances, the plan of care will not yet have been fully developed. The displacement of hands-on care is a more important consideration than the dollar cost CMS estimates, and it is absent from CMS' analysis. To the extent CMS retains a dollar-cost framing, the $399 per week per facility estimate understates the actual operational cost of adding or re-timing IDT meetings across multiple clinical disciplines, with the additional scheduling coordination and documentation those meetings require.

The proposed rule also appears to introduce an internally inconsistent approach to day-counting that, if finalized as proposed, will produce downstream confusion. The vignette in the proposed rule preamble describing a Tuesday admission and a Friday Day 4 IDT meeting suggests that CMS may be implicitly treating the day of admission as "day zero," rather than as Day 1 in the manner used elsewhere in IRF coverage and payment rules, including the 36-hour rule, the existing plan-of-care timeframe, and IRF-PAI submission deadlines. FAH urges CMS to clarify whether a "day zero" construct is intended and, if so, to reconcile that construct with other day-counted IRF requirements before finalization. The operationally appropriate result is to withdraw the Day 4 requirement. However, if CMS nevertheless proceeds to finalize this proposal and affirms the accuracy of the preamble's vignette, the day-counting construct should be explicit, internally consistent and consistent with how the day of admission is treated under all other applicable rules.

Finally, IRFs, like other Medicare-participating hospitals, are already subject to the Medicare Conditions of Participation for discharge planning at 42 CFR § 482.43, which require a discharge planning evaluation early in the patient's stay. To the extent CMS is concerned that interdisciplinary discharge planning is not adequately captured in current IRF practice, the existing Conditions of Participation already provide a framework. Adding a separate, prescriptive Day 4 IDT meeting requirement creates duplicative regulatory obligations without a corresponding clinical benefit. FAH urges CMS to withdraw the Day 4 timing requirement of the IDT meeting and to retain the existing flexibility for IRFs to schedule the initial IDT meeting at the point in the stay when it can most meaningfully inform care.

IV. REQUESTS FOR INFORMATION ON IRF PAYMENT REFORM (Part VII)

A. RFI on Modernizing the IRF PPS Using a PDPM-Style Classification Approach (Part VIII)

CMS solicits comment on a potential future redesign of the IRF PPS that would replace the current Impairment Group Code ("IGC"), Rehabilitation Impairment Category ("RIC") and Case-Mix Group ("CMG") structure with a smaller set of clinical categories aligned with the Skilled Nursing Facility (SNF) Patient-Driven Payment Model ("PDPM"). This would replace the current three-tier comorbidity adjustment with a weighted comorbidity scoring methodology drawing on PDPM's Non-Therapy Ancillary methodology and HCC/RxHCC inputs. CMS proposes 15 clinical categories, expanded from the 10 categories used under SNF PDPM, and a six-bin comorbidity score structure.

FAH appreciates CMS' interest in evaluating opportunities to modernize the IRF PPS but has concerns with the framing and substance of the RFI as currently presented. **CMS has not yet taken the foundational steps that should precede any consideration of specific structural reforms: defining the goals that any redesign should achieve; engaging the IRF community in establishing those goals; establishing a transparent, representative process for evaluating methodologies that could achieve those goals; and conducting and publishing the analyses needed to evaluate whether any proposed methodology would achieve those goals without creating unintended consequences for patient access.** By presenting a specific, detailed PDPM-style classification structure and a specific weighted comorbidity scoring methodology in the RFI, CMS has narrowed the conversation before that foundational work has occurred.

Before CMS proceeds further with this concept in any future rulemaking, FAH urges CMS to articulate the policy goals of any IRF PPS modernization, with explicit attention to protecting patient access to medically appropriate IRF care. The preservation of access should be a primary goal of any redesign, given the role of IRFs in serving patients with complex rehabilitation needs that are not appropriately met in lower-intensity post-acute settings. CMS should then convene a representative engagement process with the IRF community, including providers across ownership type, geography and case mix, clinicians, patients and families, and analytic experts, to evaluate the goals, design constraints and tradeoffs of any potential redesign before specific methodologies are presented for comment. CMS should also conduct and publish the analyses needed to assess whether the PDPM-style framework being explored would achieve the articulated goals, including simulated payment shifts at the facility, ownership-type and patient-cohort levels; analysis of access implications for patients with high-acuity rehabilitation needs (particularly stroke, traumatic brain injury, spinal cord injury and multi-trauma cohorts); and evaluation of whether borrowing SNF clinical categories adequately captures IRF case mix and the complexity of IRF patient needs. These analyses should be publicly available with sufficient lead time before any proposed rule is published to allow the IRF community and the public to substantively respond.

IRF stakeholder engagement in any future redesign effort, including through technical expert panels (TEPs), is critical. However, FAH cautions that a TEP convened *after* CMS has selected a direction or methodology will not meaningfully shape outcomes and will instead likely be a "check-the-box" function for the Agency and its contractors. For TEP engagement to be substantive and meaningful, the panel should be convened *before* methodology selection, at the point at which the policy goals, design constraints, and tradeoffs are still genuinely open. A TEP that is asked to refine a methodology CMS has already chosen serves a much narrower function, and FAH does not regard such an engagement as a substitute for the foundational community engagement described above.

In particular, and in light of the limited information provided in Acumen's technical memoranda accompanying the FY27 Proposed Rule, the FAH fundamentally questions the decision to explore the use of ICD-10 codes from prior acute hospital stays as the basis for IRF patient categorization and reimbursement. IRF patient categorization is based on coding at the IRF, which answers a fundamentally different question than patient assessment at the acute hospital: IRF patient categorization is predicated on the resources necessary to care for and rehabilitate a patient with particular functional deficits, whereas coding and assessments from the prior acute stay are focused on what resources are needed to treat and stabilize the condition that brought the patient to the hospital. The decision to shift IRF patient categorization from IRF-provided codes to acute-provided codes represents a fundamental choice that the FAH believes needs to be premised on concrete research and vetted with industry experts before moving forward.

FAH understands there may be discrete gaps in the current CMG structure that warrant attention, most notably the absence of any CMG that adequately recognizes the complexity and cost of caring for cancer rehabilitation patients, who today often rely on the high-cost outlier policy to support access. CMS could productively pursue incremental, well-defined modernization, for example developing or refining CMGs to better recognize oncology and complex cancer cases, through the normal annual rulemaking cycle, with appropriate impact analysis and stakeholder engagement, without reopening the entire IRF PPS classification architecture.

V. IRF QUALITY REPORTING PROGRAM (Part IX)

Section IX of the Proposed Rule contains one proposed change to the IRF Quality Reporting Program ("QRP") data submission deadlines and one RFI on potential future quality measure concepts focused on advance care planning. CMS proposes no changes to the 15 currently adopted IRF QRP measures.

A. Proposed Revision to IRF QRP Data Submission Deadlines (Part IX.D)

CMS proposes to revise the IRF-PAI and Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network ("NHSN") data submission deadlines beginning with the FY 2029 IRF QRP. The current 4.5-month (approximately 135 day) deadline would be replaced with a deadline of the 15th day of the second month after the end

of each calendar quarter (approximately 45 days). CMS notes that 99.08 percent of IRFs already meet the proposed timeline based on recent submission patterns.

FAH appreciates CMS' effort to make IRF QRP data timelier and more actionable for public reporting. While we do not object in principle to a shorter submission timeline, and we acknowledge that the majority of IRFs are already meeting the proposed deadline, we are concerned that hospital-based IRF units may be disadvantaged in successfully meeting this new deadline consistently. Reporting for these units is often aligned with the hospital's timelines for the Hospital Inpatient Quality Reporting Program and related programs, and competing deadlines will create operational strain and reporting burden on hospital-based IRFs whose internal validation, and submission processes must be integrated with the hospital's broader quality reporting processes.

Before finalizing this proposal, FAH urges CMS to address the following infrastructure issues that affect the small but operationally important share of submissions that occur close to or beyond the proposed deadline. The current Internet Quality Improvement & Evaluation System (iQIES) and NHSN reporting infrastructure does not provide IRFs with real-time visibility into whether submitted data have been accepted or whether errors require correction. As the deadline tightens to 45 days, real-time error feedback becomes critically important for IRFs to identify and correct issues before the deadline passes. CMS and the CDC should also commit to clear technical assistance response timeframes commensurate with the compressed submission window. When IRFs encounter system-related issues that affect their ability to demonstrate compliance, response times from CMS and CDC technical assistance contractors should allow them to successfully remediate those issues within the deadline or create a process to allow facilities to correct errors afterwards. In addition, the CDC's NHSN system was originally designed for voluntary reporting and has not fully evolved to support mandatory QRP reporting at the timeliness levels CMS now contemplates. FAH urges CMS to coordinate with the CDC to ensure that NHSN processes such as automation, data validation and group-upload functionality are sufficient to support the proposed deadline before it takes effect.

Without those infrastructure improvements, FAH is concerned that an otherwise compliant IRF could face the 2 percentage-point QRP payment reduction due to system-related issues that are outside the IRF's control. FAH urges CMS to consider these concerns carefully and, if necessary, to defer finalization of the shortened deadline until the supporting infrastructure is in place.

B. RFI on Future Measure Concepts, Advance Care Planning (Part IX.C)

CMS solicits comment on the importance, relevance, appropriateness and applicability of advance care planning ("ACP") quality measure concepts for the IRF QRP. CMS notes that no measures are proposed or under active development for near-term adoption.

FAH supports patient-centered care and recognizes that advance care planning is an important component of high-quality care across the continuum, including for patients receiving inpatient rehabilitation services. We support the concept of ACP measure development, subject to important IRF-specific implementation considerations. ACP is most appropriately addressed across the care continuum and is not typically initiated within the IRF stay; patients admitted to IRFs have often had ACP conversations during prior acute care or outpatient encounters, and any ACP measure focused on the IRF setting risks duplicating efforts that occur in upstream settings. The average IRF length of stay also constrains the ability of any IRF-based ACP intervention, and any measure should be carefully designed to avoid measuring whether a checkbox was completed rather than whether a meaningful ACP conversation occurred.

Consistent with our prior comments on other future measure concepts, FAH urges CMS to prioritize measures with high clinical relevance and minimal collection burden. Any ACP measure developed for the IRF setting should be validated and feasible to collect, sensitive to the IRF setting's relatively short length of stay for patients and tested across a national sample that includes freestanding facilities, units of acute care hospitals, urban and rural facilities, and facilities of varying size and ownership. Any measure should also allow flexibility in the form of documentation as required by individual state law and should include an exception, or guidance allowing the documentation to account for those individuals for whom an ACP conversation would be contrary to their religious and/or cultural beliefs. If CMS proceeds with ACP measure development for the IRF setting, FAH urges direct engagement with IRF clinicians and providers on measure specifications, data sources, and exclusion criteria before any measure is proposed for adoption.

Endnotes

[i] U.S. Bureau of Labor Statistics, *Consumer Price Index Summary — April 2026*, USDL-26-0721 (released May 12, 2026), https://www.bls.gov/news.release/cpi.nr0.htm.

[ii] American Hospital Association, *Costs of Caring* (March 2026), https://www.aha.org/costsofcaring.