AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

May 28, 2026

The Honorable Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1845-P
P.O. Box 8016
Baltimore, MD 21244-8016

***Delivered Electronically***

***RE: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program (CMS-1845-P)***

Dear Administrator Oz:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Federal Fiscal Year (FY) 2027 Proposed Rule, published in the Federal Register on April 6, 2026. AMRPA is the only national trade association that advocates solely for more than 800 inpatient rehabilitation facilities (IRFs), including freestanding rehabilitation hospitals, rehabilitation units within acute care hospitals, and rehabilitation units within long-term care hospitals, which focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as patients with traumatic brain injury, stroke, and spinal cord injury.

We value the Centers for Medicare & Medicaid Services' (CMS) continued partnership with AMRPA and our members, and we appreciate the agency's interest in modernizing the IRF coverage, payment, and quality reporting frameworks. As CMS considers significant coverage criteria changes for FY 2027 and in future years, AMRPA urges the agency to ensure that any reforms are tailored to the intensive and interdisciplinary nature of IRF care, protect beneficiary access, and avoid imposing new burdens that do not meaningfully improve patient outcomes. We further encourage CMS to proceed cautiously with any future IRF PPS modernization efforts given the magnitude and complexity of such effort, the potential for care and operational distortions, and to ensure that quality reporting requirements are reliable, actionable, and provide meaningful data to both patients and IRF providers.

With these overarching goals in mind, a summary of our recommendations for the FY 2027 IRF PPS follows:

## I. AMRPA Response to and Recommendations on CMS' FY 2027 Coverage Reform Proposals

1. CMS should reconsider its accelerated team conference proposal or, at minimum, delay implementation until the policy is clarified.
2. AMRPA conditionally supports CMS' therapy initiation proposal, and urges the agency to clarify numerous components of this policy before implementation.

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3. CMS should not finalize its "current functional status" reporting proposal unless or until the agency provides necessary clarification to impacted stakeholders.

## II. AMRPA Response to and Recommendations on CMS' FY 2027 Quality Reporting Program Proposals

1. AMRPA supports CMS' proposal to revise IRF QRP data submission deadlines as long as certain technical changes are adopted prior to implementation.

## III. AMRPA Response to the FY 2027 Proposed Payment Updates

1. CMS should finalize the FY 2027 IRF PPS payment update as proposed and continue to monitor whether future updates adequately reflect sustained labor and operating cost pressures facing IRFs.
2. CMS should finalize the continued application of the previously adopted phase-out policy for IRFs reclassified from rural to urban in FY 2025.
3. CMS should finalize the FY 2027 wage index methodology as proposed and carefully evaluate any future alternative data sources or methodologies for an IRF-specific wage index.
4. CMS should finalize the FY 2027 outlier threshold update as proposed and continue monitoring whether outlier payments remain adequate for the most complex IRF cases.

## IV. AMRPA Response to CMS' Requests for Information Related to Future IRF PPS & QRP Reforms

1. AMRPA has significant procedural and substantive concerns with CMS' request for feedback on ways 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.
2. AMRPA recommends that CMS not adopt or cautiously approach any adoption of advanced care planning as a future QRP measure concept.

Our more detailed comments on each of these recommendations follow:

## I. AMRPA Response to and Recommendations on CMS' FY 2027 Coverage Reform Proposals

### A. AMRPA Urges CMS to Reconsider the Accelerated Team Conference Proposal or, at Minimum, Delay Implementation Until the Policy Is Clarified

CMS proposes to amend IRF coverage regulations to require that the first interdisciplinary team conference ("IDT") occur "on or before the fourth day from midnight on the date the patient is admitted," compared to the current regulatory requirement that the IDT "occur at least once per week throughout the duration of the patient's stay." CMS cites numerous rationales for this proposed change, including concerns that IRF patients may 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 plan of care (IPOC)," and the fact that, by not providing a "timely initial IDT," the team "may be providing suboptimal treatment or inadvertently worsening the patient's health outcomes." In the proposed rule, CMS provides a hypothetical patient example in which a patient's therapists have "limited

communication with one another" in the days leading up to the first formal IDT; in comparison, the proposed accelerated IDT timeframe (in the same example) facilitated discussion about "ongoing concerns" regarding the patient's care and resulted in timely adjustments to better match the patient's functional progress. Lastly, in outlining this new timeframe, CMS appears to propose that the patient's day of admission would be a new "Day Zero," from which the "fourth day" would be calculated.

While AMRPA appreciates CMS' stated goal of promoting timely and coordinated interdisciplinary care throughout the patient's stay, we are concerned about the agency's approach to achieving this goal because it undermines the integrity of the current process that has been in place since 2010. We believe the proposal fails to understand and capture the extensive and ongoing interdisciplinary collaboration that already occurs throughout an IRF patient's stay — particularly during the critical first several days following admission. One of the features that distinguishes our hospitals and units from other post-acute care settings is the fact that inpatient rehabilitation is inherently interdisciplinary.

As our members report, rehabilitation physicians, nurses, therapists, case managers, and other members of the IRF care team engage in frequent and intensive communication beginning immediately upon admission. These communications routinely occur through bedside discussions, therapy coordination meetings, family conferences, physician consultations, nursing updates, and other less formal but highly effective clinical interactions designed to address patients' rapidly evolving medical and functional needs. We are concerned that CMS' cited concerns with "limited communications" and failures to make timely updates to patients' plans of care are theoretical, not based on evidence or practical experience, and simply incongruous with the way that care is furnished within the distinct IRF setting.

Even aside from the realities of IRF clinical practices, CMS' proposal also overlooks the fact that the existing regulatory structure already compels coordinated interdisciplinary planning shortly after admission. Specifically, the four-day timeframe associated with completion of the IPOC requires rehabilitation physicians and the interdisciplinary team to synthesize clinical findings, therapy assessments, and patient-specific goals early in the admission. As such, the proposal appears to assume a lack of interdisciplinary coordination – particularly in the early days of an IRF stay – which is simply unsupported by CMS' own reporting requirements and timeframes currently in practice in IRFs across the nation.

In addition to our concerns with the misperceptions driving this proposal, AMRPA is concerned about the potentially unanticipated clinical impacts if such policy is finalized. Requiring a formal interdisciplinary team conference within the initial four-day timeframe will not create "new" collaboration around the patient, but instead may inadvertently redirect clinical resources toward unnecessary administrative processes that do not improve patient care outcomes. In particular, AMRPA members strongly assert that the proposal could produce several unintended adverse consequences, such as:

- Limiting the flexibility that IRF clinical teams currently utilize to conduct clinically meaningful and patient-centered care coordination activities. In many facilities, less formal interdisciplinary huddles — including bedside discussions and meetings involving family members or caregivers — allow teams to respond quickly and efficiently to changing patient conditions. A rigid federally-mandated meeting timeframe may unintentionally discourage these more dynamic and individualized coordination approaches.

- Diverting clinician time away from direct patient care activities, particularly in high-volume IRFs where additional conference time will inevitably require additional staffing or pull resources from other IRF operations, including direct patient care. Furthermore, scheduling and documenting additional formal conferences within a compressed timeframe will require significant operational resources and time. These burdens are especially concerning given the existing workforce pressures affecting rehabilitation providers nationwide.

Lastly, with respect to the proposal itself, AMRPA believes that this policy is inconsistent with the Administration's broader efforts to reduce unnecessary regulatory burden within Medicare programs – particularly those requirements that drive provider costs without any corresponding patient benefit.[1] Based on our outlined concerns, we believe that CMS has not demonstrated that imposing an earlier mandatory formal conference would meaningfully improve patient care quality or outcomes while still creating new administrative and operational costs for IRF providers. AMRPA applauds many of the effective measures that the Administration has implemented to reduce burden for providers in the Medicare program, and we urge CMS to continue to advance this goal in the IRF regulatory landscape.

In addition to these substantive concerns, AMRPA also has pressing questions regarding the operational ambiguity created by the proposal itself. As drafted, the proposed rule contains apparent inconsistencies regarding how the "fourth day" is calculated across the preamble discussion, proposed regulatory text, and accompanying diagram. In the preamble text and diagram, it appears that a patient admitted on "Day Zero" (for example, a Tuesday), would then have until "Day Four" for the initial team conference – corresponding with a Saturday conference deadline (this presumes a Wednesday "Day 1," a Thursday "Day 2," and a Friday "Day 3"). However, in CMS' own patient example,[2] CMS asserts that Friday would be the latest date on which a team conference could be held. Given the intense scrutiny of team conference timeframes and reporting requirements in audits and oversight reports, it is critical that CMS' timeframe be clearly communicated to all stakeholders, with requisite training and education. For similar reasons, IRF stakeholders need clarity as to whether this "Day Zero" concept will apply across other IRF reporting requirements, most notably the IPOC.

Accordingly, if CMS elects to adopt this proposal despite stakeholder concerns, AMRPA strongly urges the agency to delay implementation for at least one year to allow CMS, Medicare contractors, and providers sufficient time to develop consistent operational guidance and ensure uniform understanding of the new requirements. Given the significant compliance implications associated with IRF coverage and documentation standards, providers must have clear and unambiguous direction regarding any revised timing obligations before enforcement begins.

**AMRPA Recommendation:** In summary, AMRPA urges CMS to maintain the current timeframe for interdisciplinary team conferences. We believe the proposal fails to capture the intensive, ongoing collaboration on IRF patient care that occurs outside of team conferences – particularly in the first part of the patient's stay while the IPOC is developed. Requiring a formal team conference to occur within the first four days would not create new or more meaningful conferences around patient care and would likely have unintended consequences in the form of staffing challenges and additional reporting requirements. It would also disrupt the cadence of the current process, where the first IDT meeting is typically used by the interdisciplinary team to assess how the patient is responding to the IPOC and adjust it after full team

[1] Executive Order No. 14192, 90 Fed. Reg. 9065 (2025)
[2] 91 Fed. Reg 17215.

collaboration. If CMS opts to pursue this policy change despite our objections, we believe that at least a one-year delay is warranted given the significant confusion around how the "fourth day" is calculated based on the language of the proposed rule. This change would mark a significant change to IRF coverage rules, and with the proposed rule itself raising numerous compliance questions, CMS must ensure that sufficient time is provided to ensure that all stakeholders and audit review entities are appropriately educated on this new coverage policy.

**B. AMRPA Supports the Overarching Goals of CMS' Therapy Initiation Proposal, But Key Policy Specifications Must be Clarified**

CMS proposes to amend IRF coverage criteria to specify that all "required" therapy treatments and/or therapy evaluations "ordered" for IRF patients must begin within 36-hours from midnight of the day of admission to the IRF. CMS notes that prior 2010 subregulatory guidance "may have created ambiguous policy" as to whether one therapy or all therapies must be initiated within 36-hours from the day of admission to the IRF, and how therapy evaluations were considered for compliance purposes.

AMRPA appreciates CMS' continued emphasis on ensuring that IRF patients receive medically necessary rehabilitation services promptly following admission, and our members already carry out their intensive care delivery and operations with this goal in mind. We therefore conditionally support the proposal to codify a timely initiation standard of all clinically appropriate, ordered therapies; however, key clarifications are needed to ensure that CMS' policy achieves these shared objectives and provides IRFs with the necessary, commonsense ability to prescribe therapies based on physician discretion and evolving patient needs.

First and foremost, we believe it is critical that the finalized policy appropriately reflects clinical practice and clearly distinguishes between the patient assessments conducted prior to admission and the physician-directed therapy plan established following admission by the treating rehabilitation physician. Specifically, AMRPA believes CMS should clarify that the therapies subject to the proposed 36-hour initiation requirement are those therapies ordered by the rehabilitation physician after the IRF admission (presumably after the patient's History and Physical), rather than the therapies referenced in the pre-admission screening documentation typically compiled during the preceding short-term acute hospital stay.

The distinction between the pre-admission screen and the physician's post-admission therapy orders is critically important. The pre-admission screen necessarily occurs prior to admission and often before the rehabilitation physician and interdisciplinary team have had the opportunity to conduct more comprehensive in-person assessments of the patient's current medical, functional, and cognitive status. By contrast, physician orders that are entered following admission reflect a more recent and holistic evaluation of the patient's rehabilitation and therapy needs. In many instances, the patient's therapy needs appropriately evolve following admission based on updated physician assessments, therapy evaluations, or changes in medical stability. For this reason, tying compliance expectations to therapies referenced in a pre-admission screening document — rather than to the physician-directed plan of care established after admission — risks creating confusion and potentially inappropriate compliance standards that do not align with individualized patient care.

The determination of which "ordered" therapies must be initiated within the 36-hour period is already an area of regulatory confusion in the IRF landscape. For example, AMRPA is aware that

Medicare Administrative Contractors (MACs) are currently taking different approaches to this policy under the Review Choice Demonstration (RCD). While AMRPA supports the underlying goals of CMS' policy proposal, it is imperative that CMS address these points as it looks to codify the timely initiation requirement in the FY 2027 rulemaking. We therefore strongly urge CMS to clarify in its final rule that therapies "ordered" by the rehabilitation physician upon admission to the IRF are those that must be initiated within 36-hours, and ensure that the standard is properly and consistently applied across the sector.

AMRPA also believes it is important that CMS explicitly confirm that therapies can be ordered later in the patient's stay without raising any compliance issues with the 36-hour initiation standard. AMRPA members have reported numerous cases where speech and language pathology was not medically appropriate upon admission, but due to changes in the patient's condition, such therapy was ordered later in the patient's stay (either during or outside the IDT, given the intensive and ongoing patient consultations described in Section IA of our comment letter). Penalizing the IRF clinical team for updating the patient's care and ordering therapy at a clinically appropriate time during the stay (rather than within the 36-hour window from midnight of the day of admission) runs counter to the goal of patient-centered care. We therefore urge CMS to confirm in the final rule that additional therapies can be initiated when medically appropriate at a later time during the patient's stay.

**AMRPA Recommendation:** AMRPA supports CMS' proposal to codify a requirement that all required therapies and/or therapy evaluations ordered begin within 36-hours from midnight of the day of admission to the IRF, so long as the "required" therapies are those "ordered" by the rehabilitation physician upon admission to the IRF. For the reasons stated above, the pre-admission screen is not an appropriate source for the therapies that must be initiated within the 36-hour period. Furthermore, to ensure that IRFs can continue to ensure that patients are receiving the intensity and volume of clinically appropriate therapy required during their IRF stay, CMS must clarify that an additional therapy can be ordered later into the patient's stay (during or outside of the IDT) without running afoul of the initiation timeframe standard. Lastly, we ask CMS to formally clarify that therapy evaluations satisfy the therapy initiation compliance standard.

### C. CMS Must Better Specify Its Proposal to Include Current Functional Status on the Pre-Admission Screen Before Codifying It in Regulation

In a brief section of the proposed rule, CMS proposes to require that a "patient's current functional status must also be documented in the PAS." This would add to the current regulatory requirement that the prior level of function is documented in the PAS.[3] CMS' rationale is that the current level of function "provides important information to build a more complete picture of [the patient's] rehabilitation trajectory and expected level of improvement while in the IRF." The proposal, however, includes no further detail as to how this new requirement would be implemented if finalized.

While requiring documentation of each patient's current functional status within 48 hours of IRF admission is reasonable, without additional and necessary context, AMRPA members are concerned that this change could raise significant operational, clinical, and audit risks depending on its implementation. While AMRPA supports collecting clinically useful bedside information to inform admission decisions, this new reporting requirement will require clear definitions, an appropriate scope, and robust safeguards.

[3] 42 C.F.R. § 412.622(a)(4)(i)(B).

AMRPA would strongly oppose use, in this instance, of the IRF Patient Assessment Instrument (IRF PAI) Section GG-type reporting mechanism for current functional status data given the significant reporting burdens, the fact that such reporting is inappropriate when a patient is in the acute care hospital, and the fact that the data could be inappropriately used for retrospective denials. It is critical that CMS specify how it plans to collect this information given the significant range of options for reporting this data, what constitutes compliance with respect to this new requirement, and the varying implications for IRF providers.

Given these concerns, CMS should not finalize this policy without specifying how "current functional status" will need to be reported and allow for stakeholders to provide meaningful comment on CMS' proposed approach from an operational and compliance perspective. We therefore urge CMS to refrain from finalizing the policy in this year's rule and instead allow stakeholders to offer feedback through future notice-and-comment rulemaking.

As CMS considers more robust proposals around this policy in the future, AMRPA would like to offer the following recommendations to ensure that any changes to the PAS reporting requirements balance CMS' goals of attaining "important information" through new data recordation while avoiding unintended operational and compliance consequences. To assist CMS in this endeavor, AMRPA would like to offer the following recommendations for future policy work:

- CMS should clarify that current functional status on the PAS is a screening tool only—intended to inform clinical triage and prepare the IRF team—not a standardized assessment for payment, case-mix adjustment, or audit comparisons.
- CMS must clarify that PAS current functional status may include non-standardized descriptors (e.g., ability to ambulate short distances, presence of dysphagia) and not require full GG scoring or motor score item sets.
- CMS must state that discrepancies between PAS current functional status and IRF admission assessments alone cannot justify retrospective claim denials. Any review that uses PAS data must consider clinical context, timing, and who performed the assessment.
- Current functional status must be able to be collected by clinical liaisons or acute care therapists using pragmatic, bedside-appropriate methods (brief observation, chart review, clinician report).
- CMS should consider a minimum 12-month delay from any future final rule adopting this policy to the implementation date to allow systems to operationalize processes, train clinicians, and update EHR workflows.

**AMRPA Recommendation:** In all, AMRPA believes that collecting current functional status on the PAS at the point of referral can be clinically useful and improve patient transfers when narrowly defined and operationalized. The current proposed rule, however, lacks the necessary detail to facilitate comment on whether CMS' approach strikes this critical balance. As such, AMRPA urges CMS to refrain from any further implementation of this policy until the agency provides a meaningful proposal for stakeholder review and comment. If and when CMS drafts such policy in the future, AMRPA urges CMS to adopt the recommendations above to ensure that current functional status is meaningfully and appropriately reported on the PAS.

## II. AMRPA Response to and Recommendations on CMS' FY 2027 Quality Reporting Program Proposals

### A. AMRPA Supports CMS' Proposal to Revise IRF QRP Data Submission Deadlines Beginning with the FY 2029 IRF QRP and Offers Technical Recommendations for Implementation

CMS is proposing that, beginning with the FY 2029 IRF QRP, IRFs must complete their data submissions and make corrections to their IRF–PAI assessment data and CDC NHSN data no later than the 15th day of the second month after the end of the calendar quarter. CMS also proposes that 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. CMS believes that reducing the deadlines will improve the timeliness of public reporting by three months, which is beneficial to both patients and IRFs, without creating new burdens.

Overall, AMRPA supports CMS' effort to reduce QRP data submission deadlines with the goal of improving the timeliness of public reporting. AMRPA has previously raised concern with the significant gaps between the time that IRF QRP measures are publicly displayed on Care Compare and the timeframe for the underlying data, and we believe this proposal is an important step towards addressing these delays. Before CMS finalizes this policy, however, AMRPA encourages CMS to adopt several technical changes to avoid unintended reporting challenges and potential compliance concerns:

- **AMRPA recommends that the data submission deadline should follow two full months from the end of a quarter, with the first day of the 3rd month set as the data submission deadline**. We believe that the extra 15-16 days will allow CMS and CDC to provide timely, confidential feedback reports to IRFs and allow sufficient time for IRFs to review and correct the IRF-PAI and CDC NHSN data to meet IRF QRP compliance standards. Especially for cases discharged towards the end of a quarter, it may take several days or weeks to finalize the data for initial submission to the CMS and CDC databases.

  Additionally, AMRPA notes that there are no IRF PPS data submission deadlines. Furthermore, payer changes, discharge clarifications, and other clinically meaningful adjustments frequently occur after initial submission. Allowing IRFs at least a month following the end of a quarter to complete initial submissions of IRF-PAI and CDC NHSN data will: (1) provide adequate time for confidential feedback reports to be supplied to IRFs; (2) allow IRFs to identify any potential issues with data adjustments; and (3) correct and resubmit any information into the IRF-PAI and/or CDC NHSN databases. This technical change will facilitate more accurate submissions while still improving the timeliness of public reporting.

- **The data submission deadline should not move if the deadline date falls on a Friday, weekend, or Federal holiday**. IRF physicians, clinicians, and other staff provide services 24 hours a day, seven days a week, negating the need for an extended deadline. Many IRFs also rely on automated reporting systems and scheduled workflows, which function best with fixed, predictable deadlines. In contrast, variable business-day deadlines increase the risk of inadvertent noncompliance without adding substantive value. Selecting a single fixed date would reduce confusion and align with CMS's stated goals of simplification, burden reduction, and timeliness of reporting. While we appreciate CMS's willingness to grant some flexibility to the IRF field for

this reporting deadline, we believe a better approach would be to affix a specific non-variable date for this reporting deadline.

- **Any accelerated submission deadline be paired with improved transparency and real-time feedback mechanisms**. AMRPA recommends the adoption of real-time (or near real-time) dashboards showing data completeness, submission status, and pending compliance issues. In addition, AMRPA urges CMS and the CDC to adopt timely and proactive communication measures in instances of system outages, technical errors, and data validation issues, as well as early notification of potential compliance issues – all of which would give providers meaningful opportunity to correct errors before facing a reporting-related payment penalty. The current system too often results in unreasonable IRF payment penalties for minimal infractions and technical reporting errors stemming from good faith reporting efforts.

- **As CMS considers shorter reporting timelines, AMRPA urges renewed attention to reducing unnecessary data collection**. AMRPA reiterates our prior specific and technical recommendations around IRF-PAI data element removal, specifically those elements that are not used for quality measurement or payment determinations. We have summarized the relevant portion of our FY 2026 IRF proposed rule comments as Appendix I; while CMS does not include a similar RFI in this year's rulemaking, we urge the agency to consider these recommendations as other changes around IRF PAI submission are contemplated.

## III. AMRPA Response to the FY 2027 Proposed Payment Updates

### A. CMS should finalize the FY 2027 IRF PPS payment update as proposed and continue to monitor whether future updates adequately reflect sustained labor and operating cost pressures facing IRFs.

AMRPA appreciates CMS' continued use of the established annual IRF PPS update methodology, which provides important predictability for inpatient rehabilitation hospitals and units. For FY 2027, CMS proposes a 3.2% market basket update reduced by a 0.8% productivity adjustment, resulting in a 2.4% net market basket update. CMS also proposes a FY 2027 labor-related share of 74.5% and a standard payment conversion factor of $19,881 after application of the applicable budget-neutrality adjustments.

The combined payment changes, along with the changes to the outlier threshold described below, would result in an estimated 2.8% increase in payments per discharge and a net increase of $355 million in payments to IRFs field wide. While AMRPA appreciates that the proposed update is positive, our members report that a positive annual update does not necessarily resolve the broader fiscal pressures facing IRFs. For example, our analysis of the CMS IRF Rate Setting file (included with the associated data files included with CMS-1845-P) suggests that over 33% (391 out of 1175) of IRFs would be projected to face negative Medicare profit margins for FY 2027, which includes 345 hospital-based IRF units of which 59 are designated as rural hospitals and another 37 are designated as teaching hospitals. AMRPA is concerned that while payment updates are made in a budget-neutral manner, at-risk providers such as rural and teaching hospitals continue to be asked to provide care for Medicare beneficiaries in a deficit position.

These findings are particularly relevant given the continued labor and operating cost pressures facing all Medicare providers. It is vitally important to protect Medicare payment adequacy for IRFs and

ensure yearly positive payment increases that support beneficiary access to medically necessary inpatient rehabilitation care. Accordingly, AMRPA supports finalization of the FY 2027 payment update, but urges CMS to continue monitoring whether future updates adequately reflect the sustained cost environment facing IRFs.

**AMRPA Recommendation:** CMS should finalize the FY 2027 IRF PPS payment update as proposed and continue to monitor whether future updates adequately reflect sustained labor and operating cost pressures facing IRFs.

**B. CMS should finalize the final year of the rural-to-urban phase-out policy for affected IRFs.**

The FY 2027 proposed rule continues the third and final year of the previously adopted 3-year phase-out of the rural adjustment for FY 2024 IRFs that transitioned from rural to urban status in FY 2025. For FY 2027, CMS now explains that affected IRFs will receive the full FY 2027 wage index with no further FY 2024 rural adjustment, completing the gradual reduction of the 14.9% rural adjustment over FYs 2025, 2026, and 2027.

This approach is consistent with AMRPA's prior positions. We support continuation of the phase-out through FY 2027 as a measured way to avoid abrupt reimbursement losses caused by geographic reclassification rather than by changes in patient need or provider performance. In other words, AMRPA believes this phased approach is preferable to a sudden loss of payment and provides greater predictability for affected providers.

**AMRPA Recommendation:** CMS should finalize the continued application of the previously adopted phase-out policy for IRFs reclassified from rural to urban in FY 2025.

**C. CMS should finalize the FY 2027 wage-index methodology as proposed and carefully evaluate any future alternative data sources or methodologies for an IRF-specific wage index.**

For FY 2027, CMS proposes to continue using the current IRF wage-index methodology. The proposed rule explains that CMS would continue to use the existing wage index framework for FY 2027, while also soliciting comments on whether it should consider alternative data sources to construct an IRF-specific wage index for potential use in future years.

AMRPA appreciates CMS' interest in evaluating whether future refinements could improve payment accuracy. At the same time, because CMS has not proposed a specific alternative methodology for FY 2027, AMRPA believes the agency should finalize the current wage index policy for this year and proceed cautiously with any future changes. Any future alternative should be transparent, empirically sound, administratively feasible, and carefully evaluated for its effects across freestanding IRFs, hospital-based units, teaching facilities, and geographically diverse labor markets. This will ensure that future payment reforms avoid unintended consequences for IRF patients and providers.

**AMRPA Recommendation:** CMS should finalize the FY 2027 wage index methodology as proposed and carefully evaluate any future alternative data sources or methodologies for an IRF-specific wage index.

### D. CMS should finalize the FY 2027 outlier threshold update as proposed and continue monitoring whether outlier payments remain adequate for the most complex IRF cases.

CMS proposes to lower the outlier threshold amount for FY 2027 to $8,689 in order to maintain outlier payments at 3% of total estimated IRF PPS payments. This represents a reduction from the FY 2026 threshold of $10,141 and would increase overall payments to IRFs by approximately 0.4% compared with FY 2026 levels.

AMRPA supports CMS' general approach to updating the outlier threshold annually in a manner intended to maintain aggregate outlier payments at the target level. Because IRFs furnish intensive interdisciplinary services to medically complex patients, an appropriately calibrated outlier policy remains an important component of the IRF PPS payment structure. At the same time, CMS should continue monitoring whether the outlier methodology appropriately captures the most complex and costly IRF cases as providers continue to face elevated labor and operating costs.

**AMRPA Recommendation**: CMS should finalize the FY 2027 outlier threshold update as proposed and continue monitoring whether outlier payments remain adequate for the most complex IRF cases.

## IV. AMRPA Response to CMS' Requests for Information Related to Future IRF PPS & QRP Reforms

### A. CMS' Request for Information on the "Modernization" of the IRF Payment System Raises Significant Procedural and Substantive Concerns

AMRPA has numerous procedural and substantive concerns with CMS' Request for Information (RFI) related to how primary diagnoses and comorbidities are used to classify patients by case-mix. Per CMS, this RFI is intended to assess whether the IRF PPS can move "toward a more robust, modernized system that is better aligned with other post-acute payment systems settings," particularly the Skilled Nursing Facility Patient Driven Patient Model (PDPM). While we appreciate some limited aspects of CMS' analysis and accompanying materials, AMRPA does not believe that this effort will help CMS achieve its intended goals, and, depending on the implementation approach and timeframe, could create significant payment and care delivery distortions that place Medicare beneficiaries at risk. Our numerous concerns, questions, and recommendations follow.

First, AMRPA has been meaningfully engaged with policymakers on IRF payment reform since enactment of the IMPACT Act in 2014. Since then, CMS and Medicare Payment Advisory Committee (MedPAC) has seriously contemplated both a unified post-acute care payment model and, when that concept was proven too complex and unlikely to succeed, MedPAC examined proposals focused on merging certain aspects of SNF and IRF payment concepts. MedPAC ultimately did not move forward with a recommendation due, once again, to the complexity around the payment systems and concerns about patient access to the most appropriate setting. We therefore question what appears to be another attempt to reform the IRF payment system based on a model that applies to an entirely different patient population treated outside a hospital setting.

If CMS is genuinely contemplating significant changes to the IRF payment system, the agency needs to be fully transparent with stakeholders to facilitate their engagement and feedback. In the FY

2027 proposed rule, however, stakeholders are not provided sufficient underlying data, methodology detail, or ICD-10 crosswalk information necessary to meaningfully evaluate the potential operational and payment implications of the concepts under consideration. Given the complexity of the IRF PPS and the significant consequences associated with potential payment redesign, providers and stakeholders must have access to comprehensive technical information to facilitate informed analysis and constructive feedback.

Additionally, AMRPA is concerned that these concepts appear to have been developed without the type of formal stakeholder engagement typically associated with major Medicare payment system reforms. To date, CMS has not convened a Technical Expert Panel ("TEP") or similar structured stakeholder process to evaluate the clinical, operational, coding, and payment implications of these proposals. Given the highly specialized nature of IRF care delivery and payment policy, robust stakeholder engagement is essential before CMS undertakes further development of these concepts.

Accordingly, AMRPA strongly recommends that CMS engage in a formal stakeholder collaboration process prior to advancing any future IRF PPS restructuring proposals. At a minimum, CMS should convene a Technical Expert Panel composed of rehabilitation physicians, therapists, IRF administrators, coding experts, health economists, Medicare payment specialists, and beneficiary representatives to evaluate potential policy changes and identify unintended consequences.

Substantively, and from the limited information that has been made available in the analyses provided by Acumen LLC, AMRPA is concerned that some of the modeling assumptions are inconsistent with clinical practice and Medicare's own guidelines related to coding principles. For example, in the Primary Diagnosis Technical Memo[4], it is suggested that a "major challenge of the current system is the ambiguity created by the potential use of up to three ICD-10 codes in the etiologic diagnosis field, which complicates the identification of the true reason for an IRF admission." This statement fails to recognize the coding guidelines available in the Appendix A of the IRF-PAI Training Manual, which clearly identify instances where certain conditions require the use of combination codes or the use of two or more ICD-10 codes, such as Traumatic Brain Injury, Traumatic Spinal Cord Injury, and Major Multiple Trauma, among others. An IRF payment system that only uses one primary diagnosis code for classification purposes would be inconsistent with coding practices; it would also potentially misclassify patients into categories that dilute clinically meaningful distinctions and risk the inappropriate classification of complex patients with multiple interacting conditions.

Similarly, AMRPA is concerned that CMS' analysis suggests combining existing unique populations of patients (with significantly different medical and functional needs and clinical care pathways) into the same classification. The most glaring example surrounds stroke patients, which are a significant portion of IRF patients and for whom clinical guidelines specifically recommend IRF care.[5] However, CMS' PDPM-based model appears to classify stroke patients along with other brain and neurological cases, which AMRPA believes raises serious concerns from both a clinical and payment perspective. We therefore urge CMS to reconsider its current approach to cross-condition classification and maintain the delineation between distinct conditions that currently exists in the IRF PPS.

[4] See: https://www.cms.gov/files/document/irf-pps-reform-primary-diagnosis-technical-memo.pdf
[5] Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. https://www.ahajournals.org/doi/10.1161/str.0000000000000098

With respect to the comorbidity binning analysis[6], AMRPA members are concerned the analysis provides limited opportunity to evaluate financial impacts or identify whether existing tiered comorbidities will be accounted for and paid for in a similar manner as they are today. While the scoring and binning process may provide opportunity for additional payment when multiple comorbidities exist, the analysis does not provide a crosswalk of ICD-10 codes that may be used nor does it provide clarity on the potential payment impacts that can be expected. The analysis also implies that the PDPM NTA methodology is the better method than the existing IRF methodology; this runs in contrast, however, with CMS' stated concern with coding issues (and subsequent necessary adjustments) in the SNF PDPM in recent SNF rulemaking.

Finally, AMRPA further urges CMS to carefully evaluate whether any future payment reforms would conflict with statutorily required components of the IRF PPS. Congress established the IRF benefit and payment system to recognize the distinct role IRFs play within the continuum of post-acute care. As such, statutory requirements about the IRF payment system require that such system reflects patients' impairment, age, comorbidities, and functional capability. Any significant restructuring of the payment methodology must remain fully consistent with this statutory framework governing IRFs, and AMRPA has serious concerns as to whether CMS' analysis achieves this objective. Preserving patient access to high-quality inpatient rehabilitation services requires a payment system specifically designed to recognize the unique characteristics of medical rehabilitation patients and the specialized care delivered within IRFs, and we urge CMS to approach any payment reform with this overarching goal in mind.

### B. AMRPA Urges CMS Not to Move Forward with Adopting Advance Care Planning as an IRF QRP Measure Concept

The FY 2027 rule also includes a Request for Information (RFI) on quality measure concepts related to advance care planning. AMRPA recognizes the importance of advance care planning across the continuum of care and supports efforts to promote person-centered care. However, based on extensive member input, AMRPA urges CMS not to move forward with advancing advanced care planning as an IRF QRP quality measure. Our key concerns include:

- Lack of measure specifications and clarity regarding intended outcomes;
- Risk of creating a process-based "checkbox" measure with limited clinical meaning;
- Limited applicability in the IRF setting, which is characterized by short lengths of stay; medically stable patients, and a recovery-focused clinical environment;
- Redundancy with existing accreditation standards (e.g., Joint Commission, CARF) that already address advance directives and patient preferences.

AMRPA members are concerned that this type of measure would increase documentation burden without meaningfully improving patient outcomes or differentiating provider performance. AMRPA also believes expectations around advanced care planning may be more appropriately addressed through accreditation processes, or internal clinical governance, rather than through a federal quality reporting program tied to payment penalties.

As CMS continues to consider other concepts that may be appropriate for the IRF QRP, AMRPA recommends the following:

[6] See: https://www.cms.gov/files/document/irf-pps-reform-comorbidity-technical-memo.pdf

- Transitions of care represent a significant area of patient risk following IRF discharge, but meaningful measurement would require improved interoperability and post-discharge data access.
- Health literacy is a promising future concept that may be more feasible to operationalize and more directly related to rehabilitation outcomes than advance care planning.

AMRPA welcomes ongoing collaboration with CMS to develop outcome-oriented, patient-centered measures that reflect the realities of inpatient rehabilitation care.

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AMRPA greatly appreciates CMS' consideration of our comments related to IRF coverage, payment and quality reporting program requirements. We believe our recommendations align with the Administration's goals of promoting high-value care while eliminating unnecessary or duplicative burdens in the Medicare program, and we stand ready to assist the Administration with technical implementation of such policies. If you have any questions, please do not hesitate to contact Kate Beller, AMRPA President (202-207-1132, kbeller@amrpa.org).

Sincerely,

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## Appendix I

As CMS considers shorter reporting timelines, AMRPA urges renewed attention to reducing unnecessary data collection. Many IRF-PAI data elements are not used in quality measurement and also not used in payment determinations. Eliminating unused data elements would directly support CMS's burden reduction goals and improve both data accuracy and provider efficiency. As AMRPA noted in our response to the Potential Future Revisions Under Consideration for the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) RFI included in the FY 2026 IRF Proposed Rule, there are as many as 214 IRF-PAI assessment data elements that are collected as SPADEs following the IMPACT Act that do not apply to the IRF QRP or IRF PPS and therefore create unnecessary administrative burden.

As detailed in our RFI response to the FY 2026 IRF Proposed Rule, the following IRF-PAI assessment data elements do not apply to the IRF QRP quality measure calculations nor IRF PPS payment which AMRPA would recommend for removal:

- Hearing, Vision, and Health Literacy
  - Element Location: These IRF-PAI data elements are located on page 5 (Admission) and page 19 (Discharge-Health Literacy) of the IRF-PAI.
  - Rationale: While these items may provide value towards patient care, it is possible that these concepts are already collected in ways that differ from what is required for the IRF-PAI, suggesting that the IRF-PAI data is duplicative of existing medical and clinical documentation.
- Signs and Symptoms of Delirium (from CAM©)
  - Element Location: These IRF-PAI data elements are located on page 7 (Admission) and page 20 (Discharge) of the IRF-PAI.
  - Rationale: Given that Delirium is complex and is difficult to measure, the existing items may be insufficient to make any determination or diagnosis. Additionally, those patients diagnosed by a physician with Delirium or Altered Level of Consciousness would be identifiable by the ICD-10 codes utilized as comorbidities, suggesting that the CAM© items are duplicative and unnecessary.
- High-Risk Drug Classes: Use and Indication
  - Element Location: These IRF-PAI data elements are located on page 16 (Admission) and page 27 (Discharge) of the IRF-PAI.
  - Rationale: While it is important to track and manage high-risk medications, this information and the considerations for use are already included in the physician orders and plan of care, and while not specifically noted, are a part of the drug regimen review process that is already tracked utilizing information from the IRF-PAI.
- Special Treatments, Procedures, and Programs
  - Element Location: These IRF-PAI data elements are located on pages 16-17 (Admission) and page 28 (Discharge) of the IRF-PAI.
  - Rationale: Similar to other IRF-PAI items, AMRPA questions the utility of this information and whether the IRF-PAI data collection is duplicative of information already contained within the medical records or claims. While these Special Treatments,

Procedures, and Programs may impact IRF care, they have not, to this date, been included as factors for payment or risk-adjustment of existing quality measures.

- Therapy Information
  - Element Location: These IRF-PAI data elements are located on page 2 of the IRF-PAI. This section requires the collection of 24 data elements relating to the various therapy types and number of minutes of each therapy type for Week 1 and Week 2.
  - Rationale: To date, CMS has not provided a report or any updated information on how this data is being used. While this information may support compliance with the "3-Hour Rule", we believe that audits utilize the therapy information in the Medical Record or Claim to make the ultimate determination on this requirement, rather than relying on the IRF-PAI report.
- Transportation
  - Location: These IRF-PAI data elements are located on page 4 (Admission) and page 18 (Discharge) of the IRF-PAI.
  - Rationale: While CMS has proposed to remove the other four SDOH items (as discussed above), the Transportation item was not proposed for removal. As previously stated in AMRPA comments on the FY 2025 IRF PPS Proposed Rule, we maintain our concerns that:
    - The updated responses do not consider the frequency of the issue or reasons why reliable transportation was not available;
    - The transportation item does not consider patients with a disability that requires special accommodations for transportation, such as the use of a wheelchair;
    - The reliability and validity of the data, especially for patients with severe cognitive deficits or pediatric patients (where this item has not been tested for patients under the age of 18), is questionable.
- Patient Mood Interview (PHQ-2 to 9) (from Pfizer Inc.©) and Social Isolation
  - Element Location: These IRF-PAI data elements are located on page 8 (Admission) and page 21 (Discharge) of the IRF-PAI.
  - Rationale: AMRPA questions the reliability and validity of the information being collected and whether this provides actionable information to incorporate into care planning. For patients experiencing a traumatic injury/event, the admission assessment of a patient's mood over the past two weeks may be negatively impacted by the injury/event and not represent a true picture of the patient's baseline status. Additionally, AMRPA members expressed concern over the requirement to collect this information on patients under the age of 12, since these assessments have not been tested or approved for use among the younger population. There are modified versions for adolescents; however, the use among pediatric patients has not been identified. Finally, the PHQ-2-9 is a screening tool for depression; however, a diagnosis may require additional assessment and testing. Also, a physician may diagnose a patient with depression or anxiety separate from the PHQ 2-9 information and this would be recorded as part of the ICD-10 codes identified as comorbidities.
- Pain Effect/Interference

- Element Location: These IRF-PAI data elements are located on pages 13-14 (Admission) and page 25 (Discharge) of the IRF-PAI.
- Rationale: AMRPA questions the utility of this information, as IRF patients experience pain following a traumatic event and may be in additional pain experienced as part of the intensive therapy provided by IRFs. Additionally, given the short duration of the typical IRF stay, it is difficult to determine whether any change from admission to discharge is measurable or statistically significant. Finally, AMRPA believes it is imperative that the collection of these data elements not lead to any unintended negative consequences, and we urge CMS to be mindful of the potential impact these items may have on the use and potential abuse of opioids. While pain management is important, any suggestion that these items are used to track a change in pain status may produce scenarios for negative unintended consequences.