AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

June 9, 2026

The Honorable Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1849-P
P.O. Box 8016
Baltimore, MD 21244-8016

***Delivered Electronically***

***RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1849-P)***

Dear Administrator Oz:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) proposed rule, published in the Federal Register on April 14, 2026. Our comments are focused solely on the proposed Comprehensive Care for Joint Replacement Expanded (CJR–X) Model, through which the Centers for Medicare and Medicaid Services (CMS) will require selected acute care hospitals to participate in a mandatory episodic payment model starting on October 1, 2027. While inpatient rehabilitation hospitals and units will not qualify as "initiators," the current model structure stands to have a significant and immediate impact on post-acute care utilization and care delivery – particularly for Lower Extremity Joint Replacement (LEJR) patients in need of inpatient rehabilitation. We therefore urge CMS to make critical CJR-X refinements with the goal of preserving patient access to medically necessary inpatient rehabilitation care and promoting longer-term functional recovery and outcomes. Without these adjustments, CMS risks inappropriately pressuring patients into suboptimal post-acute settings of care.

AMRPA is the national trade association representing more than 800 inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals or long-term care hospitals (referred to by CMS as Inpatient Rehabilitation Facilities, or IRFs). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries, such as traumatic brain injury, stroke, and spinal cord injury patients. Given the complexity and long-term trajectory of medical rehabilitation patients' care and recovery, IRF admission determinations and referrals for post-discharge services (e.g., outpatient therapy, home health services) are determined by patients' treating physicians and their multi-disciplinary care teams. This in turn drives IRF patients' strong rates of return to home and community compared to other PAC settings and helps prevent avoidable post-stay complications and readmissions.

AMRPA appreciates CMS's efforts to improve care coordination and value for Medicare beneficiaries undergoing LEJR procedures. However, based on their experience under similar models, AMRPA member hospitals are concerned that this type of mandatory, episode-based payment model

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will create strong incentives for initiators to reduce post-acute care utilization, including inpatient rehabilitation facility (IRF) care, even when such care is medically necessary and appropriate as determined by treating physicians.

AMRPA has raised these and other concerns in past comments regarding the original CJR model and the more recently implemented Transforming Episode Accountability Model (TEAM). As a global matter, AMRPA believes that target-price models that lack sufficient guardrails inappropriately incentivize hospitals to make discharge decisions based on short-term cost concerns – rather than patients' individual clinical needs, functional recovery, and long-term outcomes. AMRPA therefore urges CMS to reconsider or delay implementation of CJR–X until CMS adopts additional safeguards to protect access to medically necessary rehabilitation, preserve patient choice, and ensure adequate risk adjustment.

With these objectives in mind, AMRPA recommends that CMS address the following concerns before any further steps are taken with the proposed CJR-X program:

1. **CMS must protect access to medically necessary IRF care through robust program oversight and monitoring.**
   CJR–X should not incentivize hospitals to avoid IRF referrals for patients who need intensive rehabilitation. Models such as TEAM, CJR, and CJR-X create financial incentives to substitute lower-cost settings for IRF care, even when IRF care is clinically appropriate and may produce a better outcome for the patient. As noted in the Comprehensive Care for Joint Replacement Model - Seventh Annual Report, while CJR reduced episode costs by roughly 3%, this was driven primarily by a reduction in IRF utilization without any meaningful improvement in the quality of care. IRFs consistently demonstrate lower readmission rates, higher successful return to home and community rates, and higher rates of patients discharged at improved functional status – all of which contribute to longer-term value for the Medicare program. Additionally, a published clinical investigation titled "Comparative Effectiveness of Inpatient Rehabilitation Versus Skilled Nursing Facilities for Stroke and Hip Fracture Patients" concluded that "[f]ollowing hospitalization for stroke and hip fracture, discharge to an IRF was associated with lower mortality relative to SNF."

   Without critical guardrails, AMRPA is highly concerned that CJR-X will result in reduced patient access to medically necessary IRF care, and that negative patient outcomes will result when these patients are diverted to skilled nursing facilities (SNFs) or other settings due to their lower cost. The type and intensity of services provided by IRFs are distinctly not provided in SNFs, and a federal program such as CJR-X cannot force this type of care substitution on already-vulnerable Medicare beneficiaries. Recent oversight reports about major nursing home operators further demonstrate the inherent risk and patient safety concerns associated with programs that inappropriately divert more patients to this setting.[1]

   Therefore, to help ensure that LEJR patients receive access to high quality, medically necessary care, CMS must protect access to IRF care and closely monitor PAC referral patterns under all CMMI models, including IRF, SNF, home health, and outpatient therapy utilization. CMS

[1] See, e.g., *Ensign: The Nursing Home Empire Built on Fatal Neglect;* Hunterbrook (June 2026); available here.

should stratify this monitoring by patient complexity, hip fracture status, disability status, dual eligibility, and prior PAC use.

2. **CMS must preserve beneficiary choice and prevent steering.**
As required by law[2], hospitals are required to give beneficiaries complete and unbiased information about all clinically appropriate PAC options, including IRFs. Original CJR discharge planning rules required hospitals to inform beneficiaries of available Medicare-participating PAC providers while allowing hospitals to identify preferred providers. Similarly, in designing TEAM, CMS promulgated regulations[3] designed to ensure beneficiaries are properly notified about their inclusion in the model and preserve their freedom to receive care from any appropriate provider. These types of protections are especially critical in CJR-X given the findings of previous CMMI episode-based payment model reports that patient PAC preferences were inadequately considered and/or that patients had an inadequate understanding of where and how to care for themselves post-discharge.[4] For CJR–X, CMS should at minimum require documentation of the beneficiary's PAC preference, the clinical basis for the discharge plan, and any reason the beneficiary's preferred setting was not selected. If CJR-X is finalized, we urge CMS to fully detail how it plans to monitor and protect beneficiary freedom of choice within this new program.

3. **CMS must exclude hip fractures from CJR-X, TEAM, and all other alternative payment models**
Hip fractures are traumatic and emergent events which differ significantly from elective LEJR procedures that include prior treatment for an underlying condition such as arthritis. The ability for elective LEJR procedures to follow a predictable care pathway allows the opportunity for cost containment and efficiencies that are consistent with the goals of the CJR and CJR-X program. In contrast, hip fracture patients may present with a varying set of underlying conditions that would require careful care considerations and discharge planning that is not pre-determined or standardized in a manner that elective procedures allow for. The traumatic nature of hip fractures also requires consideration for intensive medical management and physician involvement that is typically provided in higher-cost settings - which would not allow for cost-containment strategies that are preferred and incentivized in CJR-X and TEAM.

   As mentioned previously, research has shown that hip fracture patients are at lower risk for 90-day mortality when IRF care is provided versus SNF care, and quality of care measures on Care Compare suggest that outcomes for patients who receive IRF care exceed those in other lower-cost post-acute care settings. Therefore, carving out hip fracture patients from this model would be a commonsense measure to both protect access to medically necessary care and improve outcomes for this specific patient population.

   AMRPA also notes that hip fracture patients have been identified as one of the 13 conditions of the 60% Rule, which is based upon the conditions commonly cared for by IRFs. The incentive to transition these patients to lower-cost settings fails to recognize that these patients have

[2] 42 C.F.R. § 482.43 (2026)
[3] 42 C.F.R. § 512.582 (2026)
[4] The Lewin Group, CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report (Oct. 2017). 97-98.

historically required and benefitted from the intensive, interdisciplinary, physician-led care that is unique to IRFs.

For these reasons, AMRPA urges CMS to exclude hip fractures from any future implementation of CJR-X, as well as TEAM and all other alternative payment models.

4. **CMS should strengthen risk adjustment for medically complex patients who require and would benefit from IRF care.**
AMRPA supports CMS's recognition that hip fracture/dislocation, disability, prior PAC use, and other patient-level factors should affect episode pricing. However, CJR–X risk adjustment should go further by accounting for baseline function, frailty, cognitive impairment, caregiver availability, and home environment. AMRPA is also concerned about the use of regional distinctions for target pricing, as IRF utilization may vary significantly across multi-state sectors. Should CMS move forward with CJR-X, we believe that target pricing must be created in a way that protects local utilization of IRF services and provides the opportunity for patients to receive IRF care when medically necessary and consistent with Medicare benefit policies.

5. **CMS should remove and replace proposed functional outcome measures.**
We strongly urge CMS to replace the proposed functional status measure with functional measures that are standardized and include data collected for all CJR-X episodes. Functional recovery is central to rehabilitation value and long-term Medicare savings. Without functional measures that are uniformly collected and represent 100% of LEJR episodes, CJR–X may reward short-term episode savings without capturing whether all patients regain mobility, independence, and safe community living – all of which are hallmarks of medically necessary IRF care.

   The proposed PRO-PM measure creates a score for those instances where there is a beneficiary response rate of 50 percent or greater. This suggests that the CJR-X program will compare and incentivize participant performance representative of 60% of patients against other participant performance with 90-100% of patients responding. Should a provider be penalized if they have a higher response rate if the results show lower functional progress? Alternatively, could a lower response rate indicate a bias towards positive or negative experiences?

   Since functional outcomes are important measures of care for LEJR, AMRPA recommends that CMS utilize a more reliable and more objective measure to evaluate functional recovery, where performance represents all episodes based upon standardized data collection that is performed by licensed professionals such as therapists. This eliminates any potential bias in the evaluation of function and makes sure to incentivize overall performance and not the performance on a self-selected subset of patients.

6. **CMS should minimize reporting burden.** AMRPA supports meaningful quality measurement but urges CMS to rely on existing data sources wherever possible. CMS should reduce duplicative reporting and avoid collecting data that is not already used for payment, quality, or public reporting. CJR–X should not impose new duplicative reporting obligations on IRFs or other PAC providers that are not the model participants.

7. **CMS should phase in CJR–X rather than impose immediate national mandatory participation.** If CMS moves forward with CJR-X in FY 2027 despite our aforementioned concerns, AMRPA strongly recommends that CMS adopt a phased-in or voluntary period before applying CJR–X nationally. In prior comments, AMRPA urged CMS to begin with voluntary participation and evaluation before moving to mandatory participation, particularly because episode-based models directly affect post-surgical treatment options and post-acute care referrals. At minimum, CMS should provide an extended upside-only period for hospitals newly subject to CJR–X and should exempt or delay participation for low-volume, rural, safety-net, or inexperienced hospitals.

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In conclusion, AMRPA appreciates the opportunity to comment on the proposed CJR–X model, and we urge the agency to carefully consider these concerns as it considers whether and how to move forward with the program. Certain LEJR patients – particularly those undergoing hip replacement following a fracture – require timely and clinically appropriate IRF care, and we are strongly concerned that the program may impede access to these patients as currently structured. We stand ready to provide technical assistance and identify ways to achieve CMS' goals of improving care coordination without jeopardizing the long-term value that IRFs deliver for LEJR and many other Medicare patient populations. If you have any questions, please do not hesitate to contact Kate Beller, AMRPA President (202-207-1132, kbeller@amrpa.org) and Troy Hillman, AMRPA Director of Quality and Health Policy (202-207-1129, thillman@amrpa.org).

Sincerely,

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