AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

July 21, 2026

The Honorable Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

RE: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator Oz:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 800+ member hospitals, we appreciate the opportunity to comment on the CMS' proposed rule related to Medicaid managed care state directed payment, published in the Federal Register on May 22, 2026. AMRPA is the only national trade association that solely advocates for inpatient rehabilitation hospitals and units (referred to by CMS as inpatient rehabilitation facilities, or IRFs), including freestanding rehabilitation hospitals, rehabilitation units within acute care hospitals, and rehabilitation units within long-term care hospitals. Our hospitals focus on the care and functional recovery of some the most vulnerable Medicare and Medicaid beneficiaries – such as patients with traumatic brain injury, stroke, and spinal cord injury. We are therefore concerned that, without key clarifications, the proposed rule may create access issues for Medicaid beneficiaries in need of IRF services and financial pressures for their providers. AMRPA therefore offers the following recommendations:

- IRFs should be recognized as distinct provider class for purposes of SDP arrangements in order to ensure more accurate benchmarking and allocations;
- Provider classes used in SDP regulations should reflect provider-class distinctions already recognized under federal and state law and payment policy, rather than the overly broad categorizations used in the proposed rule; and
- SDP payments should be distributed in a manner that corresponds to the provider-class distinctions on which the payment arrangement is based.

Our more detailed recommendations and rationales follow:

A. CMS Should Recognize IRFs as a Distinct Provider Type in its Final SDP Policy

In the proposed rule, CMS suggests using an upper payment limit (UPL) using a statewide average Medicare payment rate benchmark for four mandatory service categories: inpatient hospital services; outpatient hospital services; nursing facility services; and qualified practitioner services at academic

medical services. AMRPA is concerned the mandated services list – particularly the "inpatient hospital services" – is overly broad, and creates a myriad of questions for how specialized hospitals (such as IRFs) will be captured for the purposes of statewide average payment calculations.

As CMS knows, IRFs are a distinct category of hospital provider under federal law and have an entirely different payment and coverage regulatory landscape compared to short-term acute care hospitals. IRFs operate under a separate Medicare prospective payment system, which reflects the hospital-level medical management required for IRF patients coupled with the intensive, coordinated rehabilitation furnished by the IRF interdisciplinary team. These are just some of the core requirements that distinguish IRFs from general acute care hospitals, outpatient rehabilitation providers, and nursing facilities. However, the proposed rule lacks key clarifications as to how IRFs will be categorized in light of these distinct features.

CMS should also recognize that many IRFs operate as distinct rehabilitation units within acute care hospitals or long-term care hospitals. Although organizationally part of a larger institution, these rehabilitation units are separately certified as IRFs, subject to the IRF PPS and all applicable IRF coverage and regulatory requirements (and corresponding higher costs). Accordingly, these types of IRFs require the same consideration as freestanding IRFs as part of this policy.

To address AMRPA's concerns, CMS's SDP regulations should therefore clarify whether RIOF services are included in the inpatient hospital service class or create a separate category for IRF providers. Treating all hospital providers as a single class would disregard significant regulatory, clinical, operational, and payment differences among hospital types, including IRFs, long-term care hospitals (LTCHs), children's hospitals, and inpatient psychiatric facilities. Failure to recognize IRFs as a distinct provider class could prevent states from designing targeted payment arrangements that support access to intensive inpatient rehabilitation, as well as result in payment methodologies that fail to account for the specialized resources required as part of IRF care.

B. CMS Must Clarify How Different Hospital Payment Systems – Including the IRF PPS – Will Be Reflected in the SDP Benchmarks

By only proposing to use four mandated service categories, the proposed rule raises serious questions as to whether and how CMS will account for different hospital payment methodologies in its SDP policies. IRFs – as well as LTCHs, IPFs, and children's hospitals – all have very distinctive payment systems for reasons explained in Section A of our comments. Using the Inpatient Prospective Payment System (IPPS) for Medicare benchmark calculations could create serious distortions when applied to hospitals paid under different methodologies. CMS must clarify, therefore, whether future expanded Medicare benchmark calculations will be based on IRF PPS rates, IPPS rates, or a blended statewide hospital average. The IPPS or a blended methodology could serious payment disparities for rehabilitation providers and other impacted hospital types.

C. SDP Payments Must Be Distributed Consistently with Provider-Class-Level Distinctions

In addition to clarifying (and ideally, incorporating) different reimbursement structures into the SDP policy, AMRPA also asks CMS to ensure that SDP payments are similarly allocated based on such

classifications. If an SDP is established for a defined provider class, the payment methodology and distribution should logically operate at that provider-class level. Conversely, distributing payments across an overly broad provider class could dilute payments intended to address the needs of a specialized provider type – particularly IRFs. Ensuring that SDP payments are allocated by provider class will provide consistency in the application of the SDP policy and better ensure that distinct provider classes receive payment allocations that reflect the specialized nature of their services and unique patient populations.

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In closing, AMRPA urges CMS to make important clarifications regarding SDP-related provider classifications, benchmarking methodologies, and payment allocations as part of CMS' final rulemaking. AMRPA believes this would help ensure more precise and appropriate payments across provider classes, which is particularly important for the distinct types of hospitals and vital services they respectively provide to Medicaid patients across the country. 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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